Maternal and Child Health Services
Title V Block Grant

State Narrative for Virginia

Application for 2009
Annual Report for 2007

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Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Copies of signed assurances and certifications for Virginia are maintained on file in the Office of Family Health Services, Virginia Department of Health. Copies are available by contacting the Title V Director, Office of Family Health Services, 109 Governor Street, 7th Floor, Richmond, VA 23219.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

In Virginia, opportunity for public input into the MCH planning process is ongoing, utilizing the variety of stakeholders and linkages described elsewhere in the application. In 2005 Virginia focused specific efforts on obtaining public input for the five-year needs assessment and the 2006 application. These efforts included a PowerPoint presentation describing Title V and the MCH services that Virginia provides was developed and placed on the Office of Family Health Services web page (www.vahealth.org), web-based surveys that solicited input from both individual citizens and representatives of organizations that serve Virginia's women and children, stakeholder interviews, focus groups and five regional public hearings. Dr. Donna Petersen facilitated a priority- setting meeting that included both the OFHS management team and approximately eighteen external partners. The input obtained from the web surveys, the key stakeholder interviews, the public hearings and the focus groups was reviewed along with quantitative data and incorporated into the priority setting process.

Opportunity for public comment on the 2009 Title V application was publicized on the OFHS website and through direct notification of numerous stakeholders including the 35 district health departments. After transmittal to MCHB, the final application will be available on the OFHS website. The OFHS will continue to seek opportunities during FY 09 to present information on Virginia's Title V funded programs at various meetings with interested parties and obtain their input.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

In order to identify and prioritize the issues that are affecting the MCH population in Virginia, an assortment of data collection and analysis activities were used in the FY 06 needs assessment. The data included both quantitative and qualitative data. Numerous secondary datasets were obtained, such as health statistics, hospital discharge, and client level service data to investigate trends and other issues affecting the MCH population. Qualitative data came from public hearings, focus groups, key informant interviews, and an on-line survey. A CAST-5 assessment was conducted in September 2004 to identify specific strengths and weaknesses in addressing the issues affecting the MCH populations.

During the years since the completion of the needs assessment, OFHS has continued to monitor the national and state performance measure data as well as the health capacity and health status indicators. The development of the OFHS Data Mart provided more readily available data such as vital records and hospital discharge data. Staff also participated in a number of internal and external activities that required the collection and/or review of various data.

Title V funding supported both the Child Fatality and the Maternal Mortality Review Projects located in the Office of the Chief Medical Examiner (OCME). The Maternal Mortality Review Team reviewed all deaths to women within one year of the end of their pregnancy, whether that pregnancy ended with a termination, a fetal death, or a live birth. The Child Fatality Review Team conducted case reviews of non-caretaker homicides of children. Previously completed reviews include firearm deaths, suicides, unintentional injury deaths to 0-4 year olds, caretaker homicides/undetermined deaths, and hyperthermia-related deaths to children left unattended in motor vehicles.

/2009/ In October 2007, the OCME published a report on pregnancy-associated maternal deaths 1999-2001. //2009//

OFHS staff participated on the Virginia Violent Death Reporting System Advisory Committee located in the OCME. A report, titled Violent Death in Virginia: A Report from the Virginia Violent Death Reporting System, provides information on violent deaths in Virginia in 2004.

/2009/ The OCME published the 2005 Family and Intimate Partner Homicide Report in July 2007 and the Violent Death in Virginia Report in April 2008. //2009//

In 2006, the Division of Injury and Violence Prevention, with assistance from Virginia Commonwealth University, completed a follow-up to a 1996 study to gather data about attitudes, knowledge and practices related to childhood injury following ten years of injury prevention programming. The report is titled Unintentional Injuries to Children in Virginia 2006.

/2009/ The Division of Injury and Violence Prevention completed a report on injury-related hospitalizations and deaths in 2002-2006. //2009//

The Division of Injury and Violence Prevention also completed a survey to assess the knowledge, attitudes and behaviors of Virginia's health care providers concerning intimate partner violence (IVP), as well as to provide state-level estimates of providers' IPV screening practices and to identify barriers to IPV screening and treatment.

OFHS has a long-standing history of supporting the provision of genetic services for pregnant women and children. Overtime, the scope of services provided has shifted somewhat, as the private sector provider has limited services to prenatal testing on a discounted fee for service basis. The result is a perceived inconsistent service availability around the state. In 2006/2007 staff from the Divisions of Child and Adolescent Health and Women's and Infants' Health conducted a targeted needs assessment regarding genetic services for pregnant women and children.

In October 2006, Governor Kaine established the Commission on Health Reform to identify and implement national best practices at the state level regarding access, quality, and safety of care, as well as address long-term care and affordability. The Commission included four work groups: Access to Care, Quality, Transparency and Prevention, Healthcare Workforce and Long Term Care and Consumer Choices. The Quality, Transparency and Prevention Work Group focused on obesity, tobacco cessation, infant mortality and overall prevention. The final report is available at http://www.hhr.virginia.gov/Initiatives/HealthReform/index.cfm

As part of the Governor's early childhood plan, the health department convened a task group composed of all the state home visiting programs (10 different models) to explore how home visiting might support progress toward achieving the goal of "healthy children entering children "healthy children ready to learn". The Home Visiting Discussion Group met for seven months, provided recommendations to the Governor's Working Group on Early Childhood Initiatives, and has been approved to move ahead on recommendations related to infrastructure, data, and training.

/2009/ In January 2008 OFHS partnered with the Department of Medical Assistance Services (DMAS) to hold a two-day workshop on partnering to improve use of EPSDT services. MCHB and Johnson Consulting Group facilitated the discussion which resulted in a series of priorities: provider education; parent empowerment; mental health system capacity; statewide spread of developmental screening; and fostering a stronger referral system.

DMAS has measured the spread of standardized tools for developmental screening by looking at claims data. In January 2007, prior to the start of the ABCD project, the number of Medicaid claims for these screenings was 120; in January 2008 the number has increased to 275.

The Part C Early Intervention program spent 18 months conducting a comprehensive analysis and plan for system transformation. Title V staff have been actively involved on stakeholder groups. Proposed changes include: shifting the services paid by Medicaid from a rehabilitation benefit to EPSDT coverage; administrative claiming; roles of service coordinators; and fixed rates for services paid by Medicaid.

Adolescent and parent focus groups were held regarding anticipatory guidance messages found in Bright Futures Guidelines. Parents shared their major concerns about their childrens health at specific ages and what they wanted assistance with as parents; Teens provided similar information. Results were disseminated to parent education providers and used in the redesign of the Bright Futures web site. //2009//

III. State Overview

A. Overview

The Commonwealth of Virginia, a mid-Atlantic state, encompasses 40,767 square miles. It is bordered by five other states, Maryland, Kentucky, West Virginia, Tennessee, and North Carolina as well as the District of Columbia. The Chesapeake Bay defines the eastern coast. Virginia extends 440 miles from East to West and 200 miles from North to South. Local jurisdictions are comprised of 95 counties and 40 independent cities totaling 135 localities. The VDH has grouped these localities into 35 health districts. Three of the district offices, Arlington, Fairfax, and Richmond are independent with contractual relationships to the state system. (See www.vdh.virginia.gov/LHD/LocalHealthDistricts.asp for a state map showing local health districts.)

/2007/ Two of the district offices, Arlington and Fairfax are independent with contractual relationships to the state system. Effective July 1, 2006, Richmond Health Department became a part of the state system. //2007//

Across the state, the terrain varies widely, including mountainous and coastal regions, remote rural areas and large urban centers. Geography impacts services in several areas. One area of Virginia, the Eastern Shore, is actually physically connected to the state via a toll bridge/tunnel making access to the mainland services challenging. Difficult terrain, lack of medical services and transportation issues pose barriers to health care for Virginia's families.

Virginia has a great range between its urban and rural areas. Twenty-five communities have densities of less than 50 persons per square mile. Half of Virginia communities have total populations under 20,000 persons, with 24 of those having less than 10,000 persons. More that three-fourths of the state population lives within metropolitan areas, according to the U.S. Census.

According to the 2003 Census Estimate, Virginia continues to rank as the 12th most populated state with 7,386,330 residents. This is a 4.3 percent increase from 2000. Projections for the years 2000 and 2025 show the population continuing to rise to 8,466,000 persons. A large part of this growth has occurred in Northern Virginia. Virginia has 1,817,037 residents under age 18, the 14th highest child population in the country. This number represents a 21 percent increase from 1990.

The population in Virginia is 49 percent male and 51 percent female. The median age of the population is 35.7 years. Virginia has a greater proportion of younger cohorts than seen nationally. Children and teens under the age of 20 make up approximately 27 percent of the population and women of childbearing age make up approximately 22 percent of the population. In 2003, 6.7 percent of residents of the Commonwealth were under age 5 and 20.5 percent were aged 5-19.

Minority groups in Virginia include African Americans, Asian/Pacific Islanders, Native Americans, and Hispanics. The culturally diverse populations include the following groups: Cambodian, Central American, Chinese, Ethiopian, Filipino, Korean, Loa, Russian/Ukrainian, Somalian, Sierra Leone, South American, Thai and Vietnamese (VDH, Multicultural Health Task Force Report, 1999). The state ranks as 9th largest for immigrant residents and 8th among intended residence for new arrivals. In 2000 Virginia ranked as having the 16th largest Hispanic population and the 9th largest Asian population in the country. There is a continuing trend in racial and ethnic diversity in the state. The Virginia population in 2003 was 5.3 percent Hispanic compared to 2.6 in 1990, 4.5 percent Asian compared to 2.5 in 1990, and 20.4 percent African American compared to 18.8 in 1990. Multicultural population concentrations are greatest in the eastern portions of the state, with Northern Virginia and Tidewater as home to the greatest numbers of minorities. According to the 2000 Census, 10.5 percent of Virginia's children ages 5 -- 17 speak a language other than English at home.

According to the 1990 U.S. Census, three-fourths of state residents had achieved at least a high school diploma or equivalency. The 2003 American Community Summary indicates that the percentage of high school graduates or higher had risen to 84.5 percent. Overall Virginia education data compares favorably to the nation as more adults in the Commonwealth hold bachelor's degrees or have completed higher education than over two-thirds of the country. According to data from the 2003 American Community Summary, approximately 32 percent of Virginia residents hold bachelor's degrees or higher. However, percentages of educational attainment vary greatly by race and location. African Americans and Hispanics fared worse that the total state figure of high school graduates. According to 2000 data published by Annie E. Casey Foundation, 7.7 percent of teens ages 16-19 were high school dropouts down from 10 percent in 1990.

In 1998, the average annual unemployment fell to 2.9 percent. This was at the lowest level since unemployment data was first recorded in the 1970s. Virginia experienced economic fallout from the 2001 recession and the September 11th terrorist attacks with one result being decreased state revenues. Unemployment rose to 3.5 percent in 2001, yet the state average remained below the U.S. figure of 4.8 percent. The Virginia unemployment rate in March 2005 was 3.4 percent, which was below the unemployment rate of 3.9 in March 2004. Virginia's unemployment rate remains significantly lower than the national rate of 5.4 percent in March 2005. However, the unemployment rate differs across the state. The Northern Virginia and Harrisonburg areas had the lowest unemployment rate in March 2005 at 2.9 percent. The Danville area had the highest unemployment rate at 7.4 percent.

The 2002-03 two year average poverty rate in Virginia is below the U.S. figure of 12.3 percent. In 2002-03, 10 percent of Virginia's families were living at or below the Federal Poverty Level (FPL). According to Kids Count, the median income of Virginia families with children in 2001 was $58,700 compared to $51,100 nationally. Based on a 3-year average, 2001-03, Virginia ranks 13th lowest statewide poverty rate. Poverty varies significantly by locality, and by family structure. Four cities, Norfolk, Richmond, Virginia Beach, and Newport News and one county, Fairfax, account for approximately 30 percent of children in poverty.

The increase in the number of children being raised in single parent households impacts the poverty experienced by Virginia children. The 2000 Census shows a continuing increase in the number of female-headed households with children in Virginia. In 2000, female-headed households with children under eighteen years old increased from 6.0 percent of all households in 1990 to 6.9 percent in 2000. According to the Annie E. Casey Foundation, 27 percent of children in Virginia lived in a single parent family and approximately 30 percent of female-headed households with children under 18 years of age were below the poverty level in 1999. According to KIDS COUNT data, in 2001 only 31 percent of the families headed by mothers received child support or alimony. The lack of consistent child support and other support services such as reasonably priced child care remain factors that impact the many single parent families' ability to move beyond the poverty level.

Family poverty and community resources impact the ability to obtain health care. In 2004, the Virginia Health Care Insurance and Access Survey, a telephone interview survey of over 4,000 representative households in the state was completed. The survey showed that much like the U.S. as a whole, the Commonwealth's low-income population has one of the highest rates of uninsurance. The proportion of Virginia families without health insurance living at or below 150 percent of the FPL is close to or exceeds 20 percent. Rates of insurance varied from 6.3 percent for those who were uninsured all year to 11.5 percent for those uninsured at some point during 2004. Over 11 percent of adults aged 19 to 64 lacked health insurance compared to just over 6 percent of all children 18 years and younger. Young adults aged 19 to 24 had the highest rate of uninsurance. Increases in Medicaid and FAMIS (SCHIP) enrollment since 2001 have helped to lower uninsurance rates of children and pregnant women, while higher rates of unemployment and an influx of immigrants have led to an increase in the uninsured adult population. According

to this study, African Americans and Hispanics had significantly higher rates of uninsurance (11.1 percent and 27.4 percent, respectively) compared to whites. Virginians with lower education and those who had never married, were living with a partner, divorced or were separated had higher rates of uninsurance.

Health Status Indicators

Specific health status indicators highlight some of the challenges that Virginia faces. Unintentional injuries took the lives of 2,559 Virginians in 2003, making this the fifth leading cause of death. Motor vehicle crashes accounted for approximately four out of every ten of these fatalities. Although there is a continuing decline in child deaths, the leading cause of death for Virginia children is injury. Violent and abusive behavior has been increasingly recognized as an important public health issue. In 2003, 450 people were homicide victims in Virginia (down from 491 in 2001). Of the 450 homicides, the majority died by firearms and explosives. Approximately 18 percent of all the deaths in 15-19 year-olds were classified as homicides in 2003. Homicide disproportionately affects the young African American male. Forty-six youth ages 10-19 died from self-inflicted injuries in 2003.

/2007/ In 2004 unintentional injuries remained the fifth leading cause of death (2,458 deaths) and the leading cause of child death. In 2004, 398 people were homicide victims with the majority (72%) resulting from firearms. Approximately 14 percent of all the deaths in 15-19 year-olds were classified as homicides. Forty-one youth ages 10-19 died from self-inflicted injuries in 2004. //2007//

/2008/ In 2005 unintentional injuries were the 3rd leading cause of death (2,610 deaths) and the leading cause of child death. In 2005, 482 people were homicide victims with the majority (72.4%) resulting from firearms. Approximately 22% of all the deaths in 15-19 year-olds were classified as homicides. Forty-five youth ages 10-19 died from self-inflicted injuries in 2005. //2008//

/2009/ In 2006 unintentional injuries remained the 3rd leading cause of death (2,665 deaths) and the leading cause of child death. In 2006, 405 people were homicide victims with the majority (69%) resulting from firearms. Approximately 17% of all the deaths in 15-19 year-olds were classified as homicides. Thirty-seven youth ages 10-19 died from self-inflicted injuries in 2006. //2009//

The racial disparity in a number of health status indicators also presents significant challenges. For example, the infant mortality rate is often used as a state health status indicator. In 2003, the rate was 7.6 per 1,000 live births. However, there continues to be a large disparity between the rates for white and for African American infants. In 2003, the rate for white infants was 6.1/1,000 as compared to 13.9/1,000 for African American infants. The infant mortality rates vary geographically with the highest rates in Chesapeake, Hampton, Portsmouth, Richmond and Roanoke districts and in the Peninsula and Southside health districts.

/2007/ The 2004 infant mortality rate was 7.4 per 1,000 live births. The white non-Hispanic rate was 5.7: the black non-Hispanic rate was 14.1 and the Hispanic rate was 5.7. //2007//

/2008/ The 2005 infant mortality rate remained at 7.3 per 1,000 live births. The white non-Hispanic rate was 5.9, the black non-Hispanic rate was 14.4, and the Hispanic rate was 5.2. //2008//

/2009/ The 2006 infant mortality was 7.14 per 1,000 live births. The white non-Hispanic rate was 5.6, the black non-Hispanic rate was 13.8, and the Hispanic rate was 4.1. //2009//

Of Virginia women having a live birth in 2003, 84.8 percent received first trimester prenatal care. During the same period, approximately 3.8 percent of women began prenatal care in their 3rd

trimester or received no prenatal care throughout their pregnancy. There continues to be differences based on race and ethnicity, with African Americans and Hispanics less likely to have early prenatal care. The gap in early prenatal care between white mothers and African American mothers and other races in Virginia has not significantly changed from 1995 through 2003. Lower utilization by Hispanic women also reflects racial and ethnic disparities that may be magnified for immigrants who may fear contact with the medical system, encounter language barriers, or have a lack of resources and knowledge to obtain care. The Immigration and Naturalization Service estimates that the number of undocumented persons in Virginia in 2000 was 103,000, which is an increase of approximately 87 percent from 1996 to 2000. These individuals do not have access to Medicaid or FAMIS except for emergencies. Prenatal care may not be available to them potentially placing them at greater risk for a poor birth outcome.

/2007/ In 2004 84.8% of women having a live birth received first trimester prenatal care. Entry into early prenatal care continued to vary by race and ethnicity (white non-Hispanic, 89.8%; black non-Hispanic, 78.9%; and Hispanic 72.7%). //2007//

/2008/ In 2005, 84.6% of women having a live birth received first trimester prenatal care. Entry into prenatal care continued to vary by race and ethnicity (white non-Hispanic, 89.8%; black, non-Hispanic, 79.8%; and Hispanic 72.7%). //2008//

/2009/ In 2006, 83.5% of women aged 15-44 giving birth received first trimester prenatal care. Entry into prenatal care continued to vary by race and ethnicity (white non-Hispanic, 88.6%; black non-Hispanic, 79.2%; and Hispanic 68.8%). //2009//

Low birth weight is an indicator of limited access to health care and a major predictor of infant mortality. In 2003, 8.2 percent of all live births were low birth-weight infants. Of these, the percentage of low weight births for African Americans was almost double that for whites. There has been very little change in this statistic.

/2007/ In 2004, 8.2% of births were low birthweight and 1.5 % were very low birthweight. The percent for black non-Hispanic continued to be much higher than white non-Hispanic (12.6% vs. 7%). //2007//

/2008/ In 2005, the percent of births that were low birthweight or very low birthweight remained basically the same as in 2004 (8.1% low birthweight; 1.5% very low birthweight). The percent for black non-Hispanic low birthweight continued to be much higher than white non-Hispanic (12.5% vs. 7.1%). //2008//

/2009/ In 2006, the percent of births that were low birthweight was 8.2%. The percent for black non-Hispanic continued to be much higher than white non-Hispanic (12.6% vs. 7.2%). The percent of births that were low birthweight for Hispanics was 5.9%. //2009//

Pregnancy rates for teens decreased over the past five years from 34.1 per 1000 females in 1998 to 27.4 in 2003. However, the black teen pregnancy rate remained more than double that in white teens. Teen pregnancy is a critical public health issue that affects the health, educational, social, and economic future of the family. Some areas of the state had rates more than twice this level.

/2007/ The teen pregnancy rate continued to decline in 2004 to 26.5 per 1000 females. //2007//

/2008/ The teen pregnancy rate for teens aged 10-19 remained the same in 2005 (26.5 per 1000 females). The black non-Hispanic teen pregnancy rate remained more than double the white non-Hispanic rate (43.2 vs. 17.9). The Hispanic teen pregnancy rate in 2005 was 50.9. //2008//

/2009/ In 2006 the pregnancy rate for teens aged 10-19 was 27.3 per 1000 females. The black non-Hispanic teen pregnancy rate remained more than double the white non-Hispanic rate (44.8 vs. 18.2). The Hispanic teen pregnancy rate increased to 53.5 per 1000

females. //2009//

Access to Health Care

Like many other states, Virginia is experiencing what many people have referred to as a crisis in access to obstetrical care. The effects have been felt most in rural areas, but suburban and urban communities are also experiencing the effects. Several small community hospitals no longer provide obstetrical care and some obstetricians have stopped providing coverage for family practice physicians who have been delivering babies or have stopped providing supervision of certified nurse midwives. Some OB/GYNs have limited their practice to gynecology due to the prohibitive cost of malpractice insurance premiums. This has resulted in women having to travel further to the hospital or delivering in the emergency rooms or perhaps having inadequate prenatal care.

In March 2004, Governor Warner issued Executive Directive 2 establishing a work group to develop recommendations for improving accessibility of obstetrical care in Virginia's rural areas. The General Assembly adopted budget language to direct a similar study by the Secretary of Health and Human Resources to make recommendations for improving access to obstetrical care for the entire state. A workgroup consisting of General Assembly members and individuals and organizations representing rural, suburban and urban communities and interests was established. The work group received feedback from stakeholders and from the public through town hall meetings around the state, a statewide videoconference at 25 locations, and through a public e-mail address. Comments were received from more than a 1,000 Virginians.

Based on the July 1, 2004 Interim report, the Governor provided emergency authority and funding, to increase the Medicaid payment rates for outpatient obstetrical and gynecological services by 34 percent, effective on September 1, 2004. The final report, released in October 2004, includes twenty-seven recommendations in six policy areas including eligibility for services, reimbursement levels, medical malpractice, license/scope of practice, birth injury, and improving access to care. Future reports on the implementation of these recommendations will be made to the Governor and the General Assembly every two years. The full report is available at the following Web site: http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/HD522004/$file/HD52.pdf

The 1998 Session of the Virginia General Assembly included a budget amendment for FY 99-00 that provided for the implementation of a health insurance plan for low-income children. This insurance program was designed to assist working families with uninsured children and addressed the federal legislation establishing the State Child Health Insurance Program (SCHIP) under the new Title XXI of the Social Security Act. Under federal law, each state had the option to expand Medicaid, create their own children's health insurance program targeting low-income children or implement a combination of the two.

The plan that Virginia adopted in 1998 created the Children's Medical Security Insurance Plan (CMSIP). This program was designed for uninsured children who have not had health insurance for the past 12 months and who are not eligible for Medicaid or the state employee health insurance plan. This was not an expansion of Medicaid under Title XIX of the Social Security Act, but a program that provided Medicaid-equivalent benefit coverage for children in families up to 185 percent of the federal poverty level (FPL). The CMSIP did not require premiums and/or co-payments, but left the addition of premiums and/or co-payments as a future option. The Department of Social Services (DSS) was responsible for determining eligibility, enrolling people, and implementing a statewide outreach program. VDH supported the outreach effort by hosting "local health summits" to bring participants from schools, providers, community service organizations and local governments together. The state WIC program also mailed out over 100,000 packets containing CMSIP information and an application. Local health departments were also involved in CMSIP outreach efforts.

The Virginia Joint Commission on Health Care estimated that 72,000 children were eligible for

CMSIP at its inception. However, as of June 19, 2000, only 24,680 children were enrolled and by May 2001 approximately 32,000 were enrolled. Identified barriers to enrollment included the perception that CMSIP is a "welfare" program and a complicated application process. To reduce barriers and increase enrollment, CMSIP was replaced by the Family Access to Medical Insurance Security Plan (FAMIS), as mandated by Senate bill 550 in the 2000 Virginia General Assembly. (For additional information on FAMIS visit www.famis.org). FAMIS was designed to look and act like private health insurance and to be distinct from Medicaid; each utilized different applications with different eligibility requirements and no ability to transfer applications back and forth between the programs. Medicaid applications were processed at local offices of DSS, while all FAMIS applications were processed at a central processing unit. New features of this program included a premium assistance program to enroll eligible employees into their employer's health coverage using subsidies from the state.

Substantial legislative interest was directed at FAMIS during the 2002 Session of the Virginia General Assembly. Seven bills were introduced and subsequently remanded to the Joint Commission on Health Care. The Commission studied these issues in depth. As a result of their study, an omnibus bill and budget amendment were introduced and passed in the 2003 Session of the Virginia General Assembly to incorporate changes in eligibility and benefits that established the following changes:

1) Establish a single umbrella program that incorporates both Medicaid for medically indigent children and FAMIS retaining the program name of FAMIS with the Medicaid portion being known as FAMIS Plus.
2) Require use of a single application to determine eligibility for both Medicaid and FAMIS;
3) Include within FAMIS, coverage for the community-based mental health and mental retardation services provided for children enrolled in Medicaid.
4) Reduce the waiting period from six to four months between the time that a child was covered by private health insurance and when eligibility for FAMIS can be established; and
5) Amend the language that authorizes cost sharing within the FAMIS Plan to require a $25 per year per family enrollment fee and specify that the co-payment amounts shall not be reduced below the co-payment amounts required as of January 1, 2003.

In addition to this change, legislation was also passed that provided for 12 continuous months of coverage under FAMIS and FAMIS Plus if the family income does not exceed 200 percent of the federal poverty level at the time of enrollment. This change will create a more stable covered population of children by removing unnecessary administrative eligibility burdens on the family.

Accordingly, in August 2003, the Medicaid and Medicaid expansion SCHIP programs were re-named FAMIS Plus and the separate SCHIP program continued to be known as FAMIS. These major changes in FAMIS since September 2002 contributed to the continuous upward trend in enrollment. In particular, renaming children's Medicaid FAMIS Plus has made Medicaid and SCHIP relatively indistinguishable. Total enrollment for FAMIS and FAMIS Plus is currently 118,683, which represents 96 percent of the estimated eligibles.

In response to the new product branding, legislation was passed in 2004 that redefined the Outreach Oversight Committee to now become the Children's Health Insurance Advisory Committee. Their mission is to assess the policies, operations, and outreach efforts for FAMIS and FAMIS Plus and to evaluate enrollment, utilization of services and the health outcomes of children eligible for such programs. DMAS has also brought new leadership to its FAMIS program with an increased emphasis on services for pregnant women, mothers and children. Title V staff participate as a members of the Children's Health Insurance Advisory Committee and also work closely with these staff and offer assistance in program design and outreach.

In addition to these program changes, VDH incorporated the FAMIS/FAMIS Plus application into its Web Vision system (computer system for local health district operations). At a minimum, VDH staff are able to assist an eligible recipient with the application. If time permits, VDH can

electronically complete the application and then fax it directly to the Central Eligibility Processing Unit for Medicaid eligibility determinations.

/2007/ Since the FAMIS/FAMIS Plus application was made available on the local health districts' computer system, over 1,000 applications have been submitted to DMAS via VDH. Of those applications, over one-third of the applicant families have been enrolled. In 2006, DMAS was granted an 1115b waiver from CMS to extend coverage to women at time of pregnancy confirmation. This expansion has allowed woman to obtain coverage for prenatal care when it is most beneficial for positive birth outcome. As VDH works actively with this population segment, the volume of applications completed through the WebVision utility continues to rise. //2007//

/2008/ Virginia is one of the states reporting declines in Medicaid enrollment due to the federal Deficit Reduction Act that requires satisfactory documentary evidence of U.S. citizenship for Medicaid enrollment. In Virginia, the Department of Social Services (DSS) serves as the enrollment contractor for DMAS. VDH entered into an agreement with DSS to help provide necessary information to prove citizenship. If a potential recipient was born in Virginia, DSS can fax a verification form to VDH-Office of Vital Records and VDH will match the information to a birth certificate and verify citizenship. This service is being provided to DSS at half the cost of requesting a birth certificate copy. //2008//

/2009/ Virginia did document a decline in both FAMIS and FAMIS Plus enrollments in 2008, this trend can not totally be attributed to the proof of citizenship requirement. Other contributing factors included a reduction in total births and increased concern of the federal governments ability to reauthorize the SCHIP program. During this current period, trends indicate that enrollments are again on the rise. The Children's Health Insurance Program Advisory Council has formalized a research subcommittee lead by a nationally recognized health researcher. By formal analysis of eligibility forms and claims by service category, the Advisory Council will base future recommended policies on quantifiable program experiences.

DMAS also initiated two substantive outreach campaigns for FAMIS. The first campaign was targeted at working moms and featured an actual FAMIS recipient as spokesperson. This campaign was particularly successful at increasing enrollment during August (back-to- school period). The second campaign's target was teenagers. This campaign featured a teen recipient spokesperson that discussed how she discovered the program and had her parent seek enrollment following a family divorce and subsequent loss of family coverage. The FAMIS Teen Campaign also inlcuded a media sponsorship of 2008 Virginia High School League (VHSL) basketball tournament. TV viewers enjoyed 17 hours (8 championship games) in the Northern VA/Wahington, D.C., Richmond, Roanoke, Harrisonburg Charolottesville, and Norfolk viewing areas. During the games the FAMIS Teen TV ad aired 32 times and ran an additional 20 times as a PSA during the following three weeks. At any given time approximately 30,000 viewers were watching the games. This can be viewed at www.famis.org. A teen outreach program was also conducted in the Chesterfield County High Schools. FAMIS brochures, and various FAMIS giveaways such as T-shirts, backpacks and ear-buds were provided to students. //2009//

Another important legislative initiative involved the expansion of involved state agencies in the sharing of protected health information that was passed by the 2002 Virginia General Assembly as SB 264. This law was designed to clarify the authority of various state agencies to obtain and disclose protected health information in compliance with the rules promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA). The previous law covered the Departments of Health, Medical Assistance Services, Mental Health, Mental Retardation and Substance Abuse Services and Social Services. The newly defined law now includes all the agencies of the Virginia's Secretary of Health and Human Resources. Initial interagency collaboration documented over $1.2 million in cost avoidance through the sharing of health

information. The initial data sharing initiative occurred between the Departments of Health and Medical Assistance Services. A recipient match was made to all reported cases of pediatric patients with elevated blood lead levels. This allowed the Department of Medical Assistance Services to notify primary care providers of the results and subsequently follow the patients to ensure that proper monitoring and intervention had taken place. Subsequent collaborative projects involved the sharing of eligibility information and the sharing of foster child enrollment for immediate case assessment and intervention services. As the final HIPAA Security Rule has been promulgated and security audits are being completed, more data sharing projects will be developed. To facilitate this data sharing, a rule was issued by the General Assembly that requires the agencies within the Secretariat of Health and Human Services to develop a data inventory. This effort will allow all agencies to know what information are available and how it is stored. In addition, a secure mechanism for inter-agency data sharing has been established. The final report will be issued in early 2006.

In 1996, mandatory managed care enrollment in a contracted HMO began in selected counties in the Tidewater area of Virginia. To date, Medicaid managed care options are available in most areas of the Commonwealth with the exception of the southwestern counties of the state. All contracted managed care organizations (MCOs) are required to establish a program for high-risk maternity and infant cases, report to DMAS on the program components and outcome measures, and report quarterly on all births. As MCOs have demonstrated outcome improvements through their maternity programs, DMAS is reviewing the VDH BabyCare program. The current BabyCare program components are defined in regulation and have not been amended to reflect current practice. Therefore, the BabyCare program administered through the local health districts has become fragmented and some health departments have ceased providing services for reasons such as burdensome paperwork, inflexible protocols, lack of adequate mileage and general reimbursement. DMAS recognizes that the central component of BabyCare, intensive nurse case management, is of value to high-risk women. They are working closely with Title V staff to build a program that maintains essential components but is not universally prescriptive to allow for offerings that meet the needs of the marketplace.

/2007/ In the fall of 2005, a study of how BabyCare is being used in local health departments was commissioned. The report has been discussed with DMAS staff and an interagency workgroup has begun efforts to eliminate barriers. So far several significant changes to the BabyCare program have been implemented by DMAS. These include extending the timeframe requirements for client assessment and enrollment, establishing a reimbursement mechanism for assessment even if the client refuses enrollment, and increasing the mileage reimbursement rates for home visits. These immediate changes were implemented to assist health departments and other types of clinics to maintain their home visitation capacity. Title V staff continue to work with DMAS towards additional substantive changes that will lead to program improvement and increased patient access. //2007//

/2008/ VDH and DMAS have an interagency agreement that includes DMAS providing VDH with fee-for-service claims and managed care encounter data files for services provided to pregnant woman and infants. In the future, VDH will link the information to birth records, hospital discharge data and VDH program data to assess utilization of services and birth outcomes for pregnant women and infants enrolled in Medicaid. //2008//

/2009/ The linking of Medicaid data, birth records, hospital discharge data and VDH program data has been delayed until the new Medicaid Management Information Systems is developed. //2009//

The local health districts continue to be essential participants in the MCO delivery system. All provider contracts are negotiated from central office where the OFHS managed care policy analyst plays an essential role in explaining local health district services, services provided by the Children with Special Health Care Needs program, and services provided by the Child Development Clinics. The local health districts, in addition to providing public health services to

MCO enrollees, have become key partners for the Care Connection for Children network. They provide case finding services, provide local case assistance and facilitate referrals to local service organizations.

/2007/ DMAS continues to increase its MCO offerings throughout the state. A second MCO option is available in Northern Virginia and several current MCO vendors have expanded their service delivery network in southwest Virginia. The DMAS goal is to provide two MCO options in all parts of the Commonwealth. //2007//

/2008/ During the 2006 Session of the Virginia General Assembly, a bill was passed requiring DMAS to implement significant changes to the State Plan for services including voluntary enhanced benefits accounts, disease management programs and other behavior modification activities, risk-adjusted premiums for Medicaid recipients and increased employer-sponsored insurance options. Implementation of these provisions was subject to an appropriation for these activities. To date, monies have not been appropriated and the bill remains dormant.

/2009/ The national economic slowdown presented significant challenges to the state's Medicaid program. DMAS increased its promotion of the Health Insurance Premium Payment Program (HIPP) that can reimburse some or all of an enrollee's share of employer sponsored group health insurance premiums. For some persons, enrollment in the HIPP is mandatory. As a condition of Medicaid eligibility, any person who is eligible for Medicaid, is a member of an assistance unit which contains an individual employed more than 20 hours per week, and is eligible for coverage under an employer's group health plan must complete the HIPP Application Form and Medical History Questionnaire, and submit the Insurance Verification form to the employer. Anecdotal evidence has made some indication that the enrollment process is often a barrier to the clients. //2009//

During the 2007 Session of the Virginia General Assembly, a subsequent study resolution was passed requesting DMAS to study the effects of modification to the health insurance public subsidy programs. These include the Health Insurance Premium Payment program, the FAMIS Select program and the Medicare Premium Assistance program. This resolution was passed in an effort to generate strategies that would gain coverage for more families through the private insurance market. //2008//

/2009/ The Community Health Resource Center, Inc., under a contract with the Virginia Department of Health Office of Minority Health and Public Health Policy and with additional support provided by Community Health Solutions, Inc., has developed a website to provide individuals and small businesses information about the value of health coverage and how to get health insurance coverage. The website, www.InsureMoreVirginians.net, is now available for review and suggested improvements and for organizations to register as a Community Partner. //2009//

State Health Agency Strategic Priorities

House Bill 2097, passed by the 2003 General Assembly, requires that each state agency implement a state performance-based budgeting system. Since that time, an ad hoc advisory group of agency representatives designed the new planning and budgeting model that requires all state agencies to have strategic plans that are tied to their budget and use common language and format. The planning process was unveiled to agency heads by Governor Warner in December 2004. Since that time state agencies, including VDH, have developed their strategic plans and are currently developing service plans (operational plans) that are tied to the strategic plan and budgets. This significant change in state government planning and budgeting will provide for a greater understanding of how government dollars are spent and the return on investment.

As a result of this planning and budgeting process, the VDH's overall agency strategic goals include the following:
1. Provide strong leadership and operational support for Virginia's public health system
2. Prevent and control the transmission of communicable diseases.
3. Collaborate with partners in the health care system to assure access to quality health care services.
4. Promote systems, policies, and practices that facilitate improved health for all Virginians.
5. Collect, maintain and disseminate accurate, timely, and understandable public health information.
6. Respond timely to any emergency impacting public health through preparation, collaboration, education and rapid intervention.
7. Maintain an effective and efficient system for the investigation of deaths of unexplained or suspicious deaths of public interest.
8. Assure provision of clean and safe drinking water supplies.
9. Assure provision of safe food at restaurants and other places where food is served to the public.

The VDH Strategic Plan, including MCH related components, is available on the web at http://www.vdh.virginia.gov/Administration/StrategicPlan/.

State MCH Priorities

The Virginia Title V program staff collaborate with a number of agencies within the Virginia Secretariat of Health and Human Services (SHHR) to identify and jointly address the needs of the MCH populations. Regular meetings with other agencies, cross-agency program development; workgroups and special taskforces assist in the identification of issues and the prioritization of Title V efforts. These agencies within the SHHR include the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department of Social Services, Department of Medical Assistance Services, Department of Health Professions, and others. In addition, collaborative meetings with agencies outside the SHHR include the Department of Education, the Joint Commission on Health Care, the Youth Commission. Title V program staff also collaborate with and seek input from professional organizations, consumer representatives, advocacy groups and community providers as well as internally with offices within the VDH such as the Office of Minority Health, the Office of Health Policy, and the Division of STD/AIDS within the Office of Epidemiology.

For the FY 2006 needs assessment OFHS initiated special efforts to involve our external partners in setting the MCH priorities. The needs assessment process included the collection of qualitative data through public hearings, focus groups and key stakeholder interviews. In addition, Dr. Donna Petersen, Dean of the South Florida School of Public Health, facilitated a priority setting meeting of OFHS staff and external stakeholders. During the meeting the MCH priorities were developed based on the presentation of needs assessment data and the needs identified by participants.

The Title V needs assessment process served as an essential tool to reflect on system changes and examine the health status of Virginia's families. Although there have been improvements in some areas, there continues to be disparities based on race, income, age, insurance coverage and areas of the state. These variations continue to present challenges. During the next year, the Title V efforts will focus on developing and working closely with our partners to implement strategies to improve access to care, including dental care, prenatal care and breastfeeding support and expand the availability and quality of medical homes for children and women. The Title V program will also develop and promote provider education particularly in the areas of assessing and addressing risks and incorporating mental health into preventive health efforts. Our enhancement of data collection and dissemination efforts to promote evidence-based decision making in planning, policy, evaluation and allocation of resources will continue from previous years. In addition, the Title V program will begin to change our paradigm by focusing on

women across the lifespan and not just women during pregnancy. This approach recognizes and promotes the relationship between healthy girls, healthy mothers, healthy babies and healthy older adult women and will focus chronic disease prevention efforts, including healthy weight and physical activity, on women's and children's health across the lifespan.

More detailed MCH-related health status indicators are reported in the FY 2006 Needs Assessment. Virginia's MCH priorities are listed in Section IV of this application. In addition, other emerging health trends, problems, gaps and barriers are also identified in the Needs Assessment Section.

Recent Developments

/2009/ Approximately a year ago, Governor Kaine formed the Governor's Working Group on Early Childhood Initiatives with a goal of coordinating all early childhood programs under a single office of Early Childhood Development. Since then, considerable time has been spent planning and developing this new office. The new office will interface directly with the Deapartments of Education and Social Services, with a liaison to VDH linking the coordination of early childhhood programs across the agencies. On June 25, 2008, the Governor's Working Group announced that the state lead sgency for Part C early intervention will be moved from the Department of Mental Health, Mental Retardation, and Susbstance Abuse Services (DMHMRSAS) to the Department of Health. The two agencies are developing a comprehensive transition plan. A date has not been set for the official transfer of Part C responsibilities to VDH. //2009//

/2009/ The Secretary of Health and Human Resources is working with a consulting firm to review the organization and operations of three large agencies within the HHR Secretariat. The three agencies include VDH, DMHMRSAS and the Department of Social Services (DSS). The VDH review will include an assessment of the overall organizational design and structure, and a review of our human resource and training functions, and the agency's capacity to assess the productivity of clinical services that are provided through the district health departments. //2009//

B. Agency Capacity

The Office of Family Health Services (OFHS) within the Virginia Department of Health has responsibility for the development and implementation of the MCH Block Grant. The mission of Virginia's MCH efforts is to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities and strengthening the MCH infrastructure. The Office of Family Health Services is comprised of the divisions of Women's and Infants' Health, Child and Adolescent Health, Dental Health, WIC and Community Nutrition, Chronic Disease Prevention and Control and the Division of Injury and Violence Prevention. The director of the OFHS is Dr. David E. Suttle. He was appointed as director in July 2002.

/2007/ Alissa Nashwinter is the OFHS Deputy for Administration. She replaces William Bulluck the Business Manager. //2007//

/2007/ The Center for Injury and Violence Prevention is now the Division for Injury and Violence Prevention (DIVP). //2007//

MCH programs and services in Virginia are provided at each of the four levels of the MCH pyramid to protect and promote the health of women and children, including those with special health care needs.

The Division of Women's and Infants' Health assesses and advocates for the health needs of infants and of women, particularly women of childbearing age. One program provides breast and cervical cancer screening, referral and follow-up to low income Virginia women. The division also provides comprehensive family planning services in local health departments (supported in part by Title X grant funds) to assist low-income women to plan and space their pregnancies. A number of local health departments use Title V funds to provide prenatal care. Several programs aim at reducing infant mortality and morbidity through home visiting, regional coalition activities (Regional Perinatal Councils), mentoring pregnant teens (Resource Mothers), nutrition counseling, nurse case management, fetal and infant mortality reviews (FIMR), community-based projects and public and professional education. The Virginia Healthy Start program and the Breast and Cervical Cancer Early Detection Program (BCCEDP) are administered in this division. Another state program coordinates the follow-up of newly diagnosed newborns with sickle cell disease and includes public and family education, testing and counseling regarding the disease. The division recently received a federal grant to develop a web-based curriculum on perinatal depression for health care providers. The division has recently established a position to focus on women's health.

/2007/ The web-based curriculum on perinatal depression for health care providers is now available at www.perinataldepression.org Almost 400 providers completed the training and received continuing education credit in the first two months that it was available. //2007//

/2008/ Funding for the perinatal depression web site ended and the project was completed in August 2007. A new comprehensive web site funded by the National Institute of Mental Health has taken its place
(http://www.mededppd.org/aboutus.asp). //2008//

/2008/ Emmanuel Anum was hired to serve as the PRAMS Data Analyst and the epidemiologist in the Division of Women's and Infants Health. Unfortunately, he resigned to accept another position. The position is currently in recruit. //2008//

/2009/ Kristin Austin has been hired to serve as the PRAMS Data Analyst and the epidemiologist in the Division of Women's and Infants' Health. Kathleen Moline replaces Mary Zoller as the Women's and Infants' Health policy analyst. //2009//

The goal of the Division of Child and Adolescent Health is to give children, including children with special health care needs, a healthy start in life and help them maintain good health in the future. This is accomplished through the assessing health data, identifying resources, informing the public about child and adolescent health issues, assisting policy makers, supporting private and public health care providers, developing programs and information systems, identifying resources, providing clinical consultation and educational activities, and developing and distributing guidelines and educational materials. Programs administered in the division include the Abstinence Education Initiative, Teen Pregnancy Prevention Initiative, Child Lead Poisoning Prevention, Virginia Newborn Screening Services, Metabolic Treatment Services/PKU Management, Virginia Congenital Anomalies Reporting and Education System (birth defects registry), School Health, Adolescent Health, Child Development Clinics, Virginia Early Hearing Detection and Intervention Program, Virginia Bleeding Disorders Program, and Care Connection for Children. In addition, division staff participates on the Part C Early Intervention Agencies Committee, the Early Intervention Interagency Management Team, and the Virginia Interagency Coordinating Council.

/2007/ Anne Rollins was hired to serve as the State Adolescent Health Coordinator. //2007//

/2008/ Sherry Shrader, the school health nurse specialist resigned to accept the nurse manager position in the Richmond Health Department. In addition, Gale Grant, the Adolescent Sexual Health Coordinator, has also resigned to accept a position in the Richmond Health Department.

Both positions are currently in recruit. //2008//

/2009/ The Abstinence Education Initiative was discontinued in 2007. //2009//

/2009/ Janet Wright was hired to serve as the school aged health specialist. //2009//

/2007/ The Childhood Lead Poisoning Prevention program was transferred to the Office of Environmental Health within the Virginia Department of Health. Collaborative efforts relating to lead poisoning prevention will continue between the offices of Environmental Health and Family Health Services. //2007//

/2007/ The web-based curriculum on Bright Futures and EPSDT for health care providers and other child-serving professionals is now available at www.vcu-cme.org/bf //2007//

/2008/ Pat Dewey, the Virginia Early Hearing Detection and Intervention Program Manager (VEHDI) retired this year. The position is currently in recruit. //2008//

/2009/ Gayle Jones was hired to serve as the VEHDI Program manager. //2009//

The Care Connection for Children program, managed by the Division of Child and Adolescent Health, is the statewide network of centers of excellence for children with special health care needs (CSHCN) that provides leadership in the enhancement of specialty medical services; care coordination; medical insurance benefits evaluation and coordination; management of the CSHCN Pool of Funds: information and referral to CSHCN resources; family-to-family support; and training and consultation with community providers on CSHCN issues. The centers are geographically located to serve the entire state. Virginia resident children ages birth to 21 years are eligible for services if their disorder has a physical basis; has lasted or is expected to last for at least 12 months; and either requires health care and ancillary services over and above the usual for the child's age, or special ongoing treatments, interventions, or accommodation at home or school, or limits function in comparison to healthy age children; or is dependent on medications, special diet, medical technology, assistive devices or personal assistance. A limited amount of money (CSHCN Pool of Funds) is available to assist children who are uninsured or underinsured. This assistance is limited to families with a gross income at or below 300% of the Federal Poverty Level.

The Child Development Clinics, also managed by the Division of Child and Adolescent Health, is a specialized program for children and adolescents suspected of having developmental and behavioral disorders such as developmental delays, disorders of attention and hyperactivity, learning problems, mental retardation, and/or emotional and behavioral concerns. A professional team consisting of a pediatrician or nurse practitioner, nurse, social worker, educational consultant, and psychologist provide diagnostic assessment, treatment planning, follow-up care coordination and referral. Interagency coordination is provided with the Virginia Department of Education, local health departments, Part C early intervention services, mental health clinics, Head Start programs, Department of Social Services and others. Eligibility is limited to Virginia resident children under the age of 21 years. A sliding scale charge is based on income level and family size.

/2009/ The Crater Child Development Clinic is closing. OFHS is currently negotiating with the Virginia Commonwealth University's Health Systems to provide services in this area. //2009//

The Division of Dental Health's primary goal is to prevent dental disease. Dental services are provided in approximately half of Virginia's localities to pre-school and school age children who meet eligibility requirements through the local health departments. Eligibility for these services may be determined by school lunch status and/or family income. Dental services are available at health department clinics or at dental trailers placed on school property. Adult care is available on

a limited basis in certain localities. The Division of Dental Health also supports community fluoridation by monitoring water systems for compliance in conjunction with Virginia Department of Health Office of Drinking Water, reporting water system data to the Center's for Disease Control and Prevention Water Fluoridation Reporting System (WFRS), providing information about the benefits of water fluoridation to citizens and communities, and by providing grant funding for communities to start or upgrade fluoridation equipment.

The Division of Dental Health also supports the School Fluoride Mouthrinse Program through the MCH Block Grant and provides funding for fluoride mouthrinse supplies, training on implementing school mouthrinse programs, and brochures and educational information regarding the fluoride mouthrinse program. Most recently, the division implemented the "Bright Smiles for Babies" Program to targeted children from birth to three years old at highest risk for dental decay. This program's goal is to increase early recognition of disease and prevention through training dental and non-dental health professionals on oral health education and anticipatory guidance, screening and risk assessment and fluoride varnish application. The division also administers the Dental Scholarship Program that provides funding for dental students with repayment through service in dental underserved areas or eligible state agencies that provide dental services.

The WIC and Community Nutrition Services Division administers Virginia's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The programs goal is to enable women to deliver and nurture healthy children. The program serves approximately 136,000 low- to moderate-income families through local health departments and mobile clinics. The program includes outreach and education components. The division's other programs focus on increasing physical activity, reducing obesity, especially childhood obesity, promoting breastfeeding, preventing osteoporosis and preventing birth defects by promoting awareness of the importance of folic acid.

The goal of the Chronic Disease Prevention and Control Division is to reduce the human and financial burden of chronic diseases, which are the leading causes of death in Virginia. The division's prevention and control efforts include the development of programs and policies, training and state action plans that outline goals and strategies for business, civic and governmental agencies to use to control chronic diseases such as arthritis, asthma, cancer, diabetes, or heart disease and stroke. The division focuses on promoting evidence-based interventions, monitoring the burden of chronic diseases in the state, developing partnerships with other state and local agencies, and evaluating outcomes of projects' interventions. Other division efforts include outreach to promote health for persons living with disabilities and prevention of secondary chronic diseases, and to modify risk behaviors such as tobacco use, lack of physical activity and poor nutrition, which are major contributing factors leading to chronic diseases. The division manages numerous categorical CDC grants including the CDC funded Tobacco Use Control Program (TUCP). In addition, the Virginia Cancer Registry is located within this division.

The Division of Injury and Violence Prevention's vision is that Virginia will be a place where people live, learn and play safely. To reduce the impact of injury and violence, the division engages in injury assessment, the development and promotion of prevention programs and policies, and training and community education. The division also promotes and disseminates safety devices, conducts public information campaigns and funds local prevention projects. The division works collaboratively with schools and day care centers, health, social service and mental health providers, law enforcement, fire and EMS providers, and a variety of other community groups across the Commonwealth. The division's unintentional injury programs address home, school and transportation safety including passenger safety, bike safety, playground safety and fire and falls prevention. The division's violence prevention programs address sexual violence prevention, suicide, youth and domestic violence prevention.

The Office of Family Health Services is responsible for addressing several federal (e.g., Title V and Title X) and state mandates for improving the health of women and children. State statues relevant to the Virginia's Title V program authority include the following:

Virginia Congenital Anomalies Reporting and Education System (Code of Virginia Section 32.1-69). Establishes a system to collect data to evaluate the possible causes of birth defects, improve the diagnosis and treatment and establish a mechanism for informing the parents and physicians regarding available resources. This program is administered by the Division of Child and Adolescent Health.

Newborn Screening (Code of Virginia Section 32.1-65). Establishes testing requirements for newborn infants for metabolic disorders. The Division of Child and Adolescent Health administers this program.

Treatment of sickle cell (Code of Virginia Section 32.1-67). Requires the Board of Health to recommend procedures for the treatment of sickle cell diseases and provide such treatment for infants in medically indigent families.

/2007/ Effective March 1, 2006 the newborn screening panel was expanded to be consistent with the American College of Medical Genetics recommended screenings. //2007//

/2007/ Effective March 1, 2006 (Code of Virginia Section 32.1-67) was amended to make infants with a condition identified through the newborn screening program eligible for the services of the Children with Special Health Care Needs Program (Care Connection for Children) administered by the Department of Health. //2007//

Sickle Cell Screening (Code of Virginia Section 32.1-68). Establishes screening and education and post-screening counseling for individuals with sickle cell anemia or the sickle trait. (Sickle cell screening is included in newborn screening program administered by the Division of Child and Adolescent Health. The on-going education and counseling component is administered by the Division of Women's and Infants' Health.)

Newborn Hearing Screening (Code of Virginia Section 32.1-64.1). Establishes the newborn hearing screening program (Virginia Early Hearing Detection and Intervention Program). The Division of Child and Adolescent Health administers this program.

State Plan for MCH and CSHCN (Code of Virginia Section 32.1-77). Authorizes the development and submission of state plans for maternal and child health and children with special health care needs to the federal government and authorizes the state health commissioner to administer and expend federal Title V funds.

Bleeding Disorders Program (Code of Virginia Section 32.1-89). Establishes a program for the care and treatment of persons suffering from hemophilia and other related bleeding diseases who are unable to pay for the cost of services. Also establishes the Hemophilia Advisory Committee with members appointed by the Governor. This program is administered by the Division of Child and Adolescent Health.

Prenatal Testing (Code of Virginia Section 32.1-60). Requires that physicians attending a pregnant woman to examine and test for sexually transmitted diseases.

Minor's Consent for Treatment. (Virginia Code Section 54.1.2969) Requires that a minor shall be deemed an adult for the purposes of consenting to services related to birth control, pregnancy or family planning and the diagnosis and treatment of sexually transmitted disease.

Child Immunizations (Code of Virginia Section 32.1-46). Establishes immunization requirements for children. The Virginia Board of Health in conjunction with the Virginia Department of Education promulgates the rules and regulations regarding this requirement. The Division of Immunizations in the VDH Office of Epidemiology administers the state immunization program.

State Child Fatality Review Team (Code of Virginia Section 32.1-238.1). Establishes the State Child Fatality Review Team to review violent and unnatural child deaths, sudden child deaths occurring within the first 18 months of life and those fatalities where the cause cannot be determined with reasonable medical certainty. The VDH Chief Medical Examiner chairs the team that includes 16 members representing relevant state agencies and organizations.

Disclosure of Medical Records (Code of Virginia Section 32.1-40). Requires every practitioner of the healing arts and every person in charge of any medical care facility to permit disclosure of medical records to the State Health Commissioner or his designee. Under the provisions of the Code the local health officer may obtain access to medical records for the purpose of public health investigation of fetal and infant deaths, or to investigate an illness for the purpose of disease surveillance.

Preschool Physical Examinations (Code of Virginia Section 22.1-270). Requires that students entering any public kindergarten or elementary school for the first time have a physical examination that becomes a part of the student's school health record. This immunization component of the record is available for review by state and/or local health department staff. Also requires that health departments in all counties and cities conduct the preschool physical examinations for medically indigent children at no cost.

Elevated Blood-lead Testing (Code of Virginia Section 32.1-46.1, 32.1-46.2). Requires that the Board of Health establish a protocol for identification of children with elevated blood-lead levels. The regulations established by the board requires blood-lead level testing at appropriate ages and frequencies, when indicated and provides for the criteria for determining low risk elevated blood-lead levels and when testing is not indicated. This program is administered in the Division of Child and Adolescent Health.

State Health Department Public Health Programs (Code of Virginia Section 32.1-2). Requires that the Board of Health and the Virginia Department of Health administer public health programs including prevention and education activities focused on women's health, including, but not limited to, osteoporosis, breast cancer, and other conditions unique to or more prevalent among women. Also requires the development and implementation of health resource plans, the collection and preservation of vital records and health statistics and the abatement of health hazards.

The Advisory Board on Child Abuse and Neglect (Code of Virginia Section 63.2-1528). Establishes a board to advise the Department of Social Services, the state Social Services Board and the Governor on matters concerning programs for the prevention and treatment of abused and neglected children and their families. The Board consists of Governor appointees as well as relevant state agency heads including the Commissioner of Health. An OFHS staff member represents the Commissioner on this board.

Children's Health Insurance Program Advisory Committee (Code of Virginia Section 32.1-351.2). Establishes a committee to assess the policies, operations, and outreach efforts for the Family Access to Medical Insurance Security (FAMIS). An OFHS staff member serves as the Virginia Department of Health representative on this committee. In addition, the Department of Medical Assistance Services is required to enter into agreements with the Department of Education and the Department of Health to identify children who are eligible for free or reduced school lunches or WIC in order to expedite the eligibility for FAMIS.

Children with health problems or handicapping conditions (Code of Virginia Section 32.1-78). Requires the Commissioner of Health to report to the Superintended of Public Instruction or local superintendent to identify children with health problems or handicapping conditions, which may affect school work and the need for special education.

Child Restraints in Motor Vehicles (Code of Virginia Section 46.2-1097). Requires the

Department of Health to operate a program to promote, purchase and distribute child restraint devices to families who are financially unable to purchase the restraint devices. The program is funded through civil penalties. The OFHS Division for Injury and Violence Prevention administers this program.

Asthma Management Plan (Code of Virginia Section 32.1-73.5 and 73.6). Requires the Department of Health to develop, maintain, and revise a written comprehensive state plan and implement programs, using funds appropriate for that purpose, for reducing the rate of asthma hospitalizations. The plan's primary emphasis is, but not limited to, children between the ages of birth and eighteen years. The OFHS Division of Chronic Disease Prevention is responsible for this effort.

Youth Suicide Prevention (Code of Virginia Section 32.1-73.7). The Department of Health in consultation with the Department of Education, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, along with the community services boards and the local health departments, have the lead responsibility for the youth suicide prevention program. The OFHS Center for Injury and Violence Prevention is responsible for this effort.

School Health Services (Code of Virginia Section 22.1-274). Specifies that a school board may employ school nurses, physicians, physical therapists, occupational therapists and speech therapists to provide student support services. Upon approval of the local governing body a local health department may provide personnel for health services for the school district. Staff within the OFHS Division of Child and Adolescent Health Services work closely with the Department of Education's school nursing program.

School Health Advisory Boards (Code of Virginia 22.1-275.1). Requires school health advisory boards to assist with the development of health policy in school division and the evaluation of the status of schoolhealth, health education, the school evnironment, and health services and to report annually to VDH and the Virginia Department of Education on the status of student health needs.

Domestic Violence Surveillance (Code of Virginia Section 32.1-283.3). The Virginia Department of Health's Chief Medical Examiner shall provide ongoing surveillance of family violence fatalities, prepare an annual report, develop protocols for local family violence fatality review teams and serve as a clearinghouse for information. The OFHS Center for Injury and Violence Prevention works closely with the Medical Examiner's Office on this effort.

Dental Loan Repayment Program (Code of Virginia Section 32.1-122.9:1). The Board of Health is required to establish a dentist loan repayment program for graduates of accredited dental schools who meet the criteria established by the Board. These criteria require that the recipient agree to perform a period of dental service in an underserved area of the Commonwealth. The OFHS's Division of Dental Health administers this program.

Comprehensive Services for At-Risk Youth and their Families (Code of Virginia Section 2.2-2648, 2.2-5001, 2.2-5007, 2.2-5205 -- 06). The State Health Commissioner serves as a member of the Executive Council that is intended to facilitate a collaborative system of services and funding that is child-centered, family focused, and community-based when addressing the strengths and needs of troubled and at-risk youth and their families.
The Comprehensive Services for At-Risk Youth and Families also includes local health department staff on the community policy and management teams, the family assessment and planning teams and a state management team with a representative from the Office of Family Health Services.

Early Intervention Services -- Part C (Code of Virginia Section 2.2-5300 -- 2.2-5308). Establishes an early intervention agencies committee to ensure the implementation of a comprehensive

system for early intervention services as required in Part C of the federal Individuals with Disabilities Education Act (IDEA). An OFHS staff member represents the Health Commissioner serves on this committee. Also establishes local interagency councils that include local health department participants.

/2008/ Childhood Obesity (Code of Virginia Sections 22.1-23 and 32.1-19). Requires the Superintendent of Public Instruction and the State Health Commissioner to work together to combat childhood obesity and other chronic health conditions that affect school-age children. (This bill was introduced at the request of the Governor. //2008//

/2008/ House Joint Resolution 637 - Childhood Obesity. Establishes a joint subcommittee to study childhood obesity in Virginia's public schools. The subcommittee will examine the relationship between the health and physical education curriculum/ public health policies; social, economic, and cultural influences; media messages; and the incidence of overweight and obese students in the public schools. They will also examine methods to increase parental involvement and education to ensure proper nutrition of children. //2008//

/2008/ Human Papillomavirus Vaccine (Code of Virginia Section 32.1-46). Requires females to receive three doses of properly spaced human papillomavirus (HPV) vaccine. The first dose must be administered before the child enters the sixth grade. After having reviewed materials describing the link between HPV and cervical cancer, a parent or guardian may elect for his/her daughter not to receive this vaccine. The effective date is October 1, 2008. //2008//

/2008/ Minority Health (Code of Virginia Section 32.1-19). Requires the State Health Commissioner to designate a senior staff member of the Department of Health, who shall be a licensed physician, to oversee minority health efforts of the Department. (This bill was introduced at the request of the Governor). //2008//

/2008/ Women's Health (Code of Virginia Section 32.1-19). Requires the State Health Commissioner to designate a senior official of the Department, who shall be a licensed physician or nurse practitioner, to coordinate all women's health efforts in the Department. (This bill was introduced at the request of the Governor). //2008//

/2008/ Child Restraint Devices (Code of Virginia Sections 46.2-1095 and 46.2-1100). Increases the age that children must be secured in a child restraint device from five to eight and requires that rear-facing child restraint devices for infants from birth to one year shall be secured only in the back seat of motor vehicles manufactured after January 1, 1968. The bill also removes the exemption from required child restraint device use for the rear cargo area of vehicles other than pickup trucks and increases the age from less than six years old to eight years old for the permitted use of standard seat belt equipment for certain children. //2008//

/2008/ Chronic Disease Prevention (Code of Virginia Section 2.2-212). Requires the Secretary of Health and Human Resources to coordinate the disease prevention activities of agencies in the Secretariat to ensure efficient, effective delivery of health related services and financing. (This bill was introduced at the request of the Governor). //2008//

/2008/ Lead Poisoning Prevention (Code of Virginia Section 32.1-46.1). Requires the Board of Health to promulgate regulations to require physicians to make available to parents information on the dangers of lead poisoning, along with a list of available resources, as part of regular well check visits for all children. //2008//

/2008/ Pregnant Women Support Act (Code of Virginia Sections 54.1-2403.01 and 32.1-11.6). Provides that, as a routine component of prenatal care, every licensed practitioner who renders prenatal care may provide information and support services to patients receiving a positive test diagnosis for Down Syndrome or other prenatally diagnosed conditions. This bill also creates the Virginia Pregnant Women Support Fund as a special nonreverting fund to be administered by the

Board of Health to support women and families who are facing an unplanned pregnancy. //2008//

Culturally Competent Care

The OFHS is committed to providing culturally competent care for the MCH populations. This is being accomplished in a number of ways. First data is collected and analyzed according to different race and ethnic categories and used to inform program development including the targeting of resources. OFHS also collaborates with culturally diverse community groups to ensure their representation in needs assessment, program planning and evaluation. Efforts are made to ensure that brochures and health promotion materials are culturally appropriate and translated into various languages. News releases regarding public health issues are placed in newspapers that are read in different racial and ethnic communities. OFHS staff participate in cultural competency trainings when available. A recent in-service training on racial disparities sponsored by the Office of Health Policy (OHP) was attended by a number of Title V staff. Contracts with the district health departments for maternal and child health services include a requirement that care must be provided in a culturally competent manner.

/2008/ VDH has recently entered into a contract with Language Services Associates (LSA) for telephone interpreting and document translating. LSA offers interpreting and translating services in 212 languages, including all of the 50+ languages specifically required by VDH in their Request for Proposals. //2008//

The Care Connection for Children staff participated in two days of training on cultural competency provided by the Georgetown University Center for Cultural Competency.

The perinatal depression web-based training for providers utilized findings from five minority focus groups to address how to provide culturally competent screening and referral for perinatal depression.

The Virginia Department of Health's Office of Minority Health and Health Policy has recently developed a website that provides resources to assist health care providers to better meet the needs of the Commonwealth's diverse populations. The resources include training materials, research articles, assessment tools and a calendar of events. The website also provides language resources that include a list of commonly used clinical phrases in both English and Spanish. OHFS will work with the OHP to develop additional resources that specifically target the diverse MCH population. The website is available at http://clasactVirginia.vdh.virginia.gov

/2008/ Legislation requested by Governor Kaine and adopted by the 2007 General Assembly gives greater emphasis on minority health issues by directing the State Health Commissioner to designate a senior staff member who is a licensed physician to direct the Department's minority health efforts. Michael Royster, MD, MPH has been appointed to this position and will serve as the of Director of Minority Health and Public Health Policy for the Department of Health. Dr. Royster previously served as the District Health Director for the Crater Health District. //2008//

C. Organizational Structure

Mark R. Warner was sworn in as Virginia's Governor in January 2002. He became the first Democratic governor in eight years. Jane Woods, a former Virginia legislator who developed

expertise in health care while serving as the Vice-Chairman of the Joint Commission on Health Care and Chairman of its Long Term Care subcommittee, was named Secretary of Health and Human Resources. Governor Warner named Robert B. Stroube, M.D., M.P.H. who has served in the past as the State Health Commissioner, and more recently as the Acting State Health Commissioner following the departure of E. Anne Peterson, State Health Commissioner.

Unlike other states, Virginia does not permit the governor to hold consecutive terms and therefore a new governor will take office in January 2006. This will undoubtedly result in numerous changes in agency heads and new gubernatorial initiatives.

/2007/ In January 2006, Timothy Kaine, the former Democratic Lieutenant Governor was sworn in as Governor. Bill Bolling, a former Republican state senator was sworn in as Lieutenant Governor. Marilyn Tavenner was named Secretary of Health and Human Resources. Dr. Robert Stroube was reappointed as the State Health Commissioner. //2007//

/2009/ Dr. Karen Remley was appointed by Governor Kaine to serve as the State Health Commissioner following the retirement of Dr. Robert Stroube at the end of 2007. //2009//

The Virginia Department of Health is mandated by the Code of Virginia to "administer and provide a comprehensive program of preventive, curative, restorative and environmental health services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research, and abate hazards and nuisances to the health and environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth." In carrying out these responsibilities, VDH promulgates and enforces over 60 sets of regulations and manages over 70 federal and state grants. Organizationally VDH consists of a Central Office, 35 health districts, with numerous operational sites and hundreds of contractors. Three of the district offices, Arlington, Fairfax, and Richmond are independent with contractual relationships to the state system. See the Virginia Department of Health's Web site at http://www.vdh.virginia.gov/

/2007/ In July 2006, Richmond Health Department will become part of the state health department system. //2007//

Section 32.1-77 of the Code of Virginia specifically addresses VDH's authorization to prepare and submit to the U.S. Department of Health and Human Services the state Title V plan for maternal and child health services and services for children with special health care needs. The Commissioner of Health is authorized to administer the plan and expend the Title V funds.

Within the central office of VDH, the Maternal and Child Health Services Block Grant is managed by the Office of Family Health Services (OFHS). Dr. David Suttle is the OFHS director and reports directly to the Deputy Commissioner for Public Health, Dr. James Burns. Other offices under the direction of the Deputy Commissioner include the Office of Emergency Medical Services, the Office of Environmental Health Services, the Office of Drinking Water, and the Office of Epidemiology.

The administration of the Block Grant resides at the OFHS office level while divisions within the Office have specific responsibility for carrying out MCH programs. The divisions include Dental Health, Women's and Infants' Health, Chronic Disease Prevention and Control, Child and Adolescent Health, WIC and Community Nutrition and the Division of Injury and Violence Prevention. The CSHCN program resides within the Office's Division of Child and Adolescent Health. The OFHS mission and organizational placement within VDH remain the same as described in previous Maternal and Child Health Services Block Grant applications.

Title V funds are provided annually to the 35 district health departments to support maternal and child health services. The district funding levels are based on an estimate of the number of low income (200% FPL) births within each of the districts. Currently district funding addresses the

following target areas: Perinatal services, dental services, injury prevention, obesity and physical activity, breastfeeding and child health.

/2009/ The Office of Minority Health and Health Policy in collaboration with OFHS submitted a letter of intent to apply for funds from the Robert Wood Johnson Foundation. The project, if funded, would use geo-coded data to target funding to high need areas and would result in a more effective use of Title V funds. //2009//

Organizational charts for Virginia State Government, the Virginia Department of Health and the Office of Family Health Services are attached.

An attachment is included in this section.

D. Other MCH Capacity

Virginia's MCH Program, comprised of staff in the Office of Family Health Services, includes a highly skilled and diverse team of public health professionals representing a variety of disciplines. Thirty-six and a half full-time equivalent positions (FTEs) in the OFHS are funded by the MCH Block Grant. In addition, numerous district health department staff, including physicians, public health nurses, and support staff are also supported in part by Title V funds.

Senior level MCH staff in the Office of Family Health Services include the following:

David E. Suttle, M.D. is Board Certified in Pediatrics with a specialty in adolescent medicine. Dr. Suttle has served in his current capacity as Director of the Office of Family Health Services since July 2002. Previously he served in the U.S. military in direct health care administration and health policy.

Janice M. Hicks, Ph.D. has served as the Policy and Assessment Director since 1997 and as the Office of Family Health Services' Senior Policy Analyst since 1994. She has over 20 years of experience in planning, evaluation and legislative analysis. Dr. Hicks also has experience in teaching college level courses in Sociology, Research Methods, Evaluation, Social Theory, Family, and Criminology/Juvenile Delinquency. She also serves as an adjunct faculty member in the Virginia Commonwealth University's Department of Epidemiology and Community Health.

The Policy and Assessment Unit includes the grants coordinator (Robin Buskey), the State Systems Development Initiative (SSDI) Coordinator who also serves as the MCH Epidemiologist (Derek Chapman), the Behavior Risk Factor Surveillance System Coordinator (Susan Spain), the public relations coordinator (Charles Ford) and a senior health policy analyst (Kim Barnes) who continues to serve as the agency HIPAA compliance officer, the OFHS liaison to the Department of Medical Assistance Services on issues involving Medicaid and FAMIS and participates in special projects that include business intelligence applications and emergency preparedness.

Karen Day, D.D.S., M.S., M.P.H., has served in her current capacity as Director of the Division of Dental Health with the Virginia Department of Health (VDH) since 1996. Prior to this position with VDH, she served as Community Water Fluoridation Coordinator for the Division for three years and as a public health dentist for fifteen years. Dr. Day has taught graduate and undergraduate courses at Virginia Commonwealth University including biology, oral epidemiology, principals of public health and public health dentistry.

Nancy R. Bullock, R.N., M.P.H., the CSHCN Program Director, has 38 years of experience in public health in Virginia. She served as a nurse consultant, program and division director at the

state level and at the local level as a public health nurse and nurse manager. She has been the director of the CSHCN Program since 1991.

Joan Corder-Mabe, R.N.C., M.S., W.H.N.P., was selected as the Director for the Division of Women's and Infants' Health in 2001. Previously she served as the perinatal nurse consultant since 1992 and the Acting Director since 1998. She is responsible for programs including the Title X Family Planning, the Virginia Healthy Start Initiative, the CDC Breast and Cervical Cancer Early Detection Program, Partners in Prevention, the Resource Mothers Program, Women's Health, the Regional Perinatal Councils, and the Comprehensive Sickle Cell Program. She and the division staff also provide consultation and technical assistance to the local health departments serving perinatal clients.

Joanne S. Boise has served as Director of the Division of Child and Adolescent Health since June 2001. Prior to joining VDH, Ms. Boise spent fifteen years in the managed care industry working locally and nationally; she has held positions in health policy, HMO operations, quality improvement, utilization management, and network management. She holds an A.A.S. in Nursing (1979), B.A. in History (1976), and M.S.P.H. in Health Policy and Administration (1986).

Donna Seward, B.S., has served in her current capacity as the Director of the Division of WIC and Community Nutrition Services (DWCNS) since April 2000. She is responsible for the management of Virginia's WIC program. From 1976 to 2000 she served as the WIC Director at the local level in Texas. Her educational background is in health care management.

Erima S. Fobbs, B.Sc, M.P.H., is the Director of the Division of Injury and Violence Prevention (DIVP). Her M.P.H. includes a concentration on Epidemiology and Health Services Administration. Prior to becoming involved in injury prevention, she worked for one year as an evaluator on an AIDS education program targeted for minority communities. Her injury prevention career began in Canada in 1988 when, as the epidemiologist on a project at the University of Alberta, she prepared the first comprehensive report on injury epidemiology in Alberta and wrote a proposal leading to the permanent establishment and funding of the Alberta Injury Prevention Center. Her employment at the Virginia Department of Health began in 1994. Since that time she has developed a statewide injury and violence prevention program and directs staff in delivering services that include a resource information center, assessment, data analysis and reporting, state and community level prevention, training and education projects. She has also taught courses on the Epidemiology and Prevention of Intentional Injury as an adjunct assistant professor at MCV/VCU Department of Preventive Medicine and Public Health.

In the fall of 2004, OFHS contracted with the Virginia Commonwealth University's School of Public Health to hire a faculty level MCH epidemiologist. Derek Chapman, Ph.D. has been hired in this jointly appointed position that is supported by SSDI funds. Dr. Chapman previously served as the Director of Research at the Tennessee Department of Health and has a number of years of experience working with MCH data. He works closely with the division level epidemiologists to establish greater access to data including the development of linked data. He also works closely with the Behavior Risk Factor Surveillance System (BRFSS) Coordinator, the Director of the Center for Health Statistics and the Office of Information Management. The joint appointment of Dr. Chapman provides an opportunity for greater collaboration between the OFHS and the School of Public Health. It is anticipated that this arrangement will have benefits for both OFHS and the University through increased opportunities for grants, student internships, technical assistance and publications.

In April 2005 Susan Kennedy Spain, M.S. was hired to serve as the BRFSS Coordinator. She has fifteen years of experience in data analysis and project management. She previously was employed by the Virginia Commonwealth University's Survey Evaluation and Research Lab (SERL). She has expertise in survey development and evaluation. She will be working closely with the MCH Epidemiologist to implement a routine surveillance system so that data will be routinely collected, analyzed and made available for use in program evaluation and decision

making within the office.

/2007/ Caroline Stampfel joined the Policy and Assessment Unit in September 2005. She has a 2-year fellowship sponsored by the Council of State and Territorial Epidemiologists (CSTE). Her work is focused primarily on MCH epidemiology. She received her MPH from Yale University in 2005. //2007//

/2008/ Caroline Stampfel successfully completed her CSTE fellowship and has been hired as a full time state employee in the OFHS. She works closely with the MCH Epidemiologist to implement a routine MCH surveillance system. //2008//

/2009/ Caroline Stampfel is currently serving as the SSDI coordinator. //2009//

/2008/ A new CSTE fellow has been assigned to Virginia and will begin work in the summer. She will also work closely with the MCH Epidemiologist in the Policy and Assessment Unit. In addition, a graduate student from the MCHB Graduate Student Internship Program (GSIP) is working with the Policy and Assessment Unit this summer. //2008//

/2009/ A graduate student from the MCHB Graduate Student Internship program (GSIP) is working with the Policy and Assessment Unit this summer. She is focusing on the analysis of the BRFSS data in relation to women of child bearing age. //2009//

/2008/ In order to continue to increase our capacity and to better use our available resources, the Policy and Assessment Unit has created a team to review all research and evaluation proposals. The review team, made up of Policy and Assessment staff as well as research-related representatives from the Divisions, work closely with Division staff to review plans for research and evaluation activities to be completed in-house or through a contractor.

The benefits of this new review process include:

A decrease in the duplication of research and evaluation activities that occur across the OFHS divisions;
An increase in the amount of funding available for program activities and a decrease in the amount of funding spent on research and evaluation activities;
An increase in the research and evaluation capacity of OFHS program staff;
An increase in collaboration across the OFHS divisions;
An increase in the identification of qualified contractors;
An increase in OFHS staff support in developing their research activities; and
An increase in oversight of all research and evaluation activities to ensure that work that is contracted out is reasonable, cost-effective, and necessary. //2008//

/2008/ In April 2006, Virginia was awarded a PRAMS grant. Michelle White was hired to serve as the PRAMS coordinator. She formerly served as the Division of Injury and Violence Prevention's epidemiologist. //2008//

/2009/ Marilyn Wenner was hired as the PRAMS coordinator. Marilyn has approximately 15 years of public health experience. //2009//

/2009/ Virginia was awarded a CDC Assessment Initiative Grant in 2007. Michelle White is now the Virginia Assessment Initiative Coordinator. The purpose of the 5 year grant is to enhance community health assessment activities in the VDH central office and the 35 local health districts through the provision of timely, accurate, and standardized data and information. //2009//

/2009/ Virginia was awarded a CDC grant to support the implementation of Youth Risk

Behavior Survey (the Virginia Youth Survey). The Coordinator position is currently in recruit. //2009//

Family Involvement

OFHS provides a number of opportunities for family input into the MCH and CSHCN programs. A parent feedback survey is used to assess the services provided by Care Connection for Children centers, Bleeding Disorders Program, and the Child Development Clinics. Five of the six Care Connection for Children (CCC) centers have employed parents of CSHCN as parent coordinators. The sixth center has plans to do this in 2008. In addition, the centers have contractual relationships with the coordinators of Virginia Family Voices, Parent to Parent, and Medical Home Plus to provide outreach, support, mentorship, and training to parents. They have assisted the Care Connection for Children centers in establishing their family-to-family support services. Parents from Family Voices and Parent to Parent provided input into Virginia's state CSHCN plan to meet the Healthy People 2010 goals. Parent focus groups have provided input for various MCH related programs including the Lead Program and Abstinence. Family representatives serve on the Regional Perinatal Councils, the Hemophilia Advisory Board, the Fetal Alcohol Spectrum Disorder Task Force, the Virginia Early Hearing Detection and Intervention Advisory Committee and its Parent Subcommittee, the Virginia Lead Task Force and the Virginia Genetics Advisory Committee. OFHS staff also participate in a number of organizations with families such as the Virginia Chapter of the Hemophilia Foundation, Spina Bifida Foundation, Cystic Fibrosis Foundation, Virginia SIDS Alliance, Virginia Parents Against Lead, and the Virginia Congress of Parents and Teachers. During 2005, CSHCN staff joined with parents and professionals from other state agencies and formed the Virginia Family Support Coalition which is committed to improving information and referral services for CSHCN and their families.

/2008/ The Association of Maternal and Child Health Programs (AMCHP) changed their by-laws to allow states to have an additional family liaison delegate. Dana Yarbrough, Executive Director of Parent to Parent of Virginia has agreed to serve as Virginia's family liaison delegate to AMCHP. Dana currently works closely with Virginia's Care Connection for Children (the CSHCN program) //2008//

/2009/ The Virginia Integrated Network of Family Organizations (Va INFO) Center, which was previously called the Virginia Family Support Coalition, was awarded a MCH Family to Family Information and Education Center grant in 2008. The new funding will expand center activities to include peer to peer and systems advocacy training for families of children currently served by Virginia's Care Connection for Children network //2009//

E. State Agency Coordination

In Virginia, state health and human services agencies are organized under the jurisdiction of the cabinet level Secretary of Health and Human Resources who is appointed by the governor. The major health and human services agencies include the Department of Health, the Department of Medical Assistance Services, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and the Department of Social Services. The Departments of Juvenile Justice and Corrections, and the Department of Education are located under different cabinet secretaries. The Health and Human Resources Secretariat also includes a number of advisory boards that provide opportunities for coordination including the Governor's Advisory Board on Child Abuse and Neglect, the Child Day Care Council and the Governor's Substance Abuse Services Council.

There are also ongoing opportunities to work with Virginia's health education programs and universities. For example, OFHS recently contracted with the Virginia Commonwealth University's (VCU) Department of Preventive Medicine and Community Health for the services of a faculty level MCH epidemiologist to work within the OFHS. VCU serves as the contractor for Virginia's

Behavior Risk Surveillance Survey (BRFSS) and also provides assistance with trainings, research and report writing and evaluations of programs such as the Teen Pregnancy Prevention Initiative and the Abstinence Education Initiative. Most recently, VCU completed a Women's Health Data Book and is currently completing a report on child hospitalizations. OFHS has also worked closely with the Center for Pediatric Research, Eastern Virginia Medical School (EVMS), in conducting surveys of perinatal providers on practice issues regarding perinatal depression, children's hospitalizations, and the development of a school health information system. Virginia Polytechnic Institute and State University (VPI&SU) also provided assistance in coalition building and program evaluation. The University of Virginia (UVA) recently provided assistance related to youth violence prevention activities.

/2007/ The University of Virginia assisted in the development of the provider web-based training on perinatal depression. //2007//

/2009/ VCU is no longer the contractor for the Virginia Behavior Risk Surveillance Survey (BRFSS). The contract was awarded to MACRO beginning in 2007. VCU is the contractor for the PRAMS project. //2009//

Currently OFHS contracts with Welligent (associated with EVMS) for the maintenance of client data systems including the Virginia Infant Screening and Infant Tracking System (VISITS), a web-based integrated database system that will track screening results for four programs and services: Virginia Newborn Hearing Screening Program, Virginia Congenital Anomalies Reporting and Education System (VaCARES), Early Hearing Detection and Intervention, and Infant and Toddler Connection (Part C of the Individuals with Disabilities Education Act (IDEA). The CSHCN Program, through a contractual agreement with EVMS/Welligent, implemented the Care Connection for Children System Users Network (CCC-SUN), a web-based database system. This software application is for the network of the six Care Connections for Children centers to document their services and report them to the CSHCN Program. Contracts with the tertiary care centers for genetic consultation/services and for specialized services for children with special health care needs are also maintained.

/2007/ VDH has brought the Virginia Infant Screening and Tracking System as well as CCC-SUN in house under the Office of Information Management (OIM) for database management. Currently Welligent is contracted for programming services. Through a CDC grant funded project awarded in 2005, the Office of Information Management is redesigning VISITS, which will be integrated with the electronic birth certificate web-based system. The Virginia Child Health Information Systems Integration Project will include automatic and semi-automatic referrals to Infant and Toddler Connection (Part C of the Individuals with Disabilities Education Act (IDEA) and Care Connection for Children, and the project will examine the feasibility of linking VISITS with other child health databases, such as CCC-SUN and Lead Trax. //2007//

The Department of Medical Assistance Services (DMAS) continues to bring the public and private sector together to address issues related to service delivery for mothers and children. The Managed Care Advisory Committee and its subgroup, the Managed Care Workgroup, continue to address problems with enrollment, access, and retention. The committee is comprised of representatives from the six contracted Medicaid managed care organizations, VDH Title V representatives, and the departments of Mental Health and Social Services. One of the significant accomplishments was the streamlining of eligibility determinations for pregnant woman. Through a contract with a private processing unit, a pregnant woman can now be enrolled and assigned a treating physician within 30 days to 45 days of application. Therefore, their access to prenatal services can now be accomplished during their first trimester.

Pursuant to legislation passed during the 2004 Session of the Virginia General Assembly, DMAS has brought together the public and private sector to address insurance coverage for children. The Child Health Insurance Advisory Committee (CHIPAC) has representation from state agencies, private industries, providers and consumers. The purpose of the group is to make

policy recommendations concerning children's access to and utilization of health care services. Although in its infancy, this group has the support of senior management at DMAS and also members of the Virginia General Assembly. Kim Barnes, OFHS Policy Analyst, participates on the advisory committee.

An interagency agreement exists between VDH and DMAS for the coordination of Titles V and XIX services. The assignments of responsibilities as stated in the agreement are intended to result in improved use of state government resources and more effective service delivery by assuring that the provision of authorized Medicaid services is consistent with the statutory function and mission of VDH. The agreement has been modified to include a Business Associate Agreement for the purpose of data sharing. The current data sharing projects involve the exchange of blood-lead testing results, eligibility information and decedent information. In addition to the value of improved health status in the Commonwealth, these projects save the state approximately $1.2 million annually.

The interagency agreement also includes coordination of Medicaid and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). The agreement includes mechanisms to assist eligible women and infants to obtain Medicaid coverage and WIC benefits. In addition, the Maternal Outreach Program - a cooperative agreement which expands the VDH Resource Mothers Program - supports the coordination of care and services available under Title V and Title XIX by the identification of pregnant teenagers who are eligible for Medicaid and assisting them with their eligibility applications.

DMAS directs the EPSDT Program and collaborates with the VDH and DSS on specific components of the program. VDH interagency responsibilities include, when appropriate, (1) providing consultation on developing subsystem and data collection modifications and (2) collaborating on (a) modifying the Virginia EPSDT Periodicity, (b) developing screening standards and procedure guidelines for EPSDT providers, (c) developing materials to be included in the EPSDT Supplemental Medicaid Manual and other provider notices as may be required, (d) providing EPSDT educational activities targeted to local health departments, (e) implementing strategies that will increase the number of EPSDT screenings, and (f) making available current EPSDT program information brochures and other materials that are needed to communicate information to local health department patients. A web-based EPSDT training program is currently under development and will be marketed to Medicaid providers by DMAS.

/2007/ The web-based curriculum on Bright Futures and EPSDT for health care providers and other child-serving professionals is now available at www.vcu-cme.org/bf //2007//

In 1987, the Department of Medical Assistance Services, with the Departments of Health and Social Services, developed a plan for care coordination and other expanded services called Baby Care. The program services include outreach and care coordination for high-risk pregnant women and infants, education, counseling on nutrition, parenting and smoking cessation and follow-up and monitoring. With the advent of Medicaid Managed Care, the participating HMOs were allowed to develop proprietary Baby Care programs that met the objectives articulated in the 1987 regulations. These programs demonstrated significant improvements in birth outcomes. As the various programs were researched by DMAS, it has become evident that new Baby Care program guidance be established. This process is currently underway with an expected roll out date in early 2006.

/2007/ The school health nurse specialist participated in numerous trainings with DMAS staff on Bright Futures, EPSDT, and childhood lead screening. //2007//

A Memorandum of Understanding between VDH and the Virginia Department of Social Services covers the expectations related to the use of TANF funding to support the VDH Teen Pregnancy Prevention program, the Resource Mothers Sibling program (GEMS), Statutory Rape Awareness program and the Partners in Prevention program. The Title V program staff work closely with the

DSS staff to ensure that the TANF funding addresses the needs of the MCH population.

The OFHS contracts with the six regional sites that make up the Statewide Human Services Information and Referral System, administered by the Virginia Department of Social Services, for information and referral services for the MCH Helpline. The toll-free number is 1-800-230-6977. The system has been helping Virginians since 1974. This number also serves as the state number for the National Baby Line to provide information and referral for prenatal care. Data documenting maternal and child health related service calls are collected and reported to the OFHS quarterly as required by the contract. This information provides data for future needs assessments and program. Copies of the most recent contracts are on file in the OFHS.

/2007/ During the past year the Statewide Human Services Information and Referral System implemented a "211" number that can be dialed from any location in the Commonwealth except the Northern Virginia Area. "211" access will be available in the Northern Virginia Area in the future. In 2005, over 44,000 calls relating to maternal and child health were received. //2007//

/2008/ In 2006, over 55,000 requests for MCH-related information were received by the Statewide Human Services Information and Referral System. The "211" number remains unavailable in the Northern Virginia area, however this area accesses the I&R through the "800" number. //2008//

/2009/ The "211" number is now available in all areas of the state. //2009//

Children with Special Health Care Needs

The Division of Child and Adolescent Health's Care Connection for Children (CCC) and the Child Development Clinic Services (CDC) programs have provider agreements with the Department of Medical Assistance Services. Copies of these agreements are on file in the Office of Family Health Services and are reviewed periodically. The CCC and CDC programs bill Medicaid for physician, laboratory, psychological, and hearing services. In the past, DCAH worked with DMAS to revise several state-specific reimbursement codes ("Y" and "Z" codes) used for CSHCN.

A collaborative relationship has also been established between the Care Connection for Children Program, the Social Security Administration Field Office in Virginia and the Disability Determination Services in the Virginia Department of Rehabilitative Services to enhance each program's roles and responsibilities pertaining to the SSI beneficiaries. Strategies for publicizing each program, facilitating application for benefits and services, expediting referrals, acquisition of medical and other evidence, and reciprocal training about programs available to children with disabilities are continuing.

An interagency agreement exists between VDH and the Department of Education (DOE) for the inclusion of educational consultants as members of the interdisciplinary teams in CDC and CCC centers. The consultants provide liaison services among the clinics and centers, the children's families and local education agencies serving the children. Duties include administering and interpreting developmental and/or educational evaluations; identifying learning styles, strengths, and weaknesses; recommending educational strategies and modifications; consulting with school personnel regarding modifications in school programs; monitoring and reevaluating progress of the children; and providing staff development. DOE provides the position and funding and contracts with a local school division to provide the supervision and fiscal management of the position. VDH provides the housing and secretarial support and participates in the evaluation of the educational consultants.

The Title V program has established and maintains ongoing interagency collaboration for systems building in some defined areas. The Title V program collaborates with DOE to develop and maintain guidelines for school health services for CSHCN, such as the First Aid Guide for School Emergencies (Revised 2003) and the Guidelines for Specialized Health Care Procedures

(Revised 2004). VDH and the Virginia Chapter of the American Lung Association have established the Virginia Asthma Coalition to assess needs, share information, and collaborate on the use of available resources.

Other Collaborative Agreements

The Commissioner of the Department of Health serves on the Early Intervention Agencies Committee that was established in 1992 through Section 2.1-760-768 of the Code of Virginia to ensure the implementation of a comprehensive system of early intervention services for infants and toddlers. A representative from the DCAH is an active participant on the Virginia Interagency Coordinating Council (VICC) and the Part C Interagency Management Team. At the local level, professional staff from the health departments and the Child Development Clinics serve on the local interagency coordinating councils.

The Comprehensive Services Act for At-Risk Youth and Families provides a comprehensive, coordinated, family-focused, child-centered, and community-based service system for emotionally and/or behaviorally disturbed youth and their families throughout Virginia. One representative from VDH/Title V serves on the State Executive Council and another serves on the State and Local Advisory Team (SLAT). Other representatives from the state and local health departments serve on workgroups. All local health departments and/or Child Development Clinics serve on local community policy and management teams and family assessment and planning teams.

The Title V funded programs are also coordinated with other health department programs that serve a common population group including Immunization, STD/AIDS, and Emergency Medical Services. Immunizations are provided as part of local health department services as are family planning and well-child services. Screening and treatment for STDs are provided in family planning clinics. Family planning, prenatal, and well child patients may be referred to health department dental services.

Intra-agency and interagency collaboration will continue with the above mentioned agencies and others such as, WIC, the Office of Primary Care and Rural Health, Title X -- Federal Family Planning Program, the Commission on Youth, the Virginia Commission on Health Care, the VDH Office of Health Policy, the VDH Office of Minority Health, the Virginia Primary Care Association, and the Virginia Hospital and Health Care Foundation. In addition, Title V staff will continue to support community-based organizations that have been working to improve the health of the MCH population including organizations such as the Virginia Perinatal Association, the Virginia Association of School Nurses, the Virginia Chapter of the March of Dimes and numerous single disease oriented voluntary organizations.

Title V staff will continue to represent the MCH interest on numerous interagency councils, task forces and committees such as the Governor's Office for Substance Abuse Prevention (GOSAP), the Governor's Council on Substance Abuse Services, and the Governor's Advisory Board on Child Abuse and Neglect, and the Child and Family Behavioral Health Policy and Planning Committee.

To facilitate the work of the Secretary of Health and Human Resources, the Title V program staff will continue to provide analysis and recommendations to the Governor on legislation before the General Assembly that will directly affect VDH programs and women's and children's health in Virginia. OFHS staff will continue to review and comment on legislation, regulations, and standards of other state agencies from a maternal and child health perspective.

Copies of all interagency agreements are maintained on file in the Office of Family Health Services and are reviewed and amended as required.

A more comprehensive list of interagency work groups, advisory groups and other collaborative

relationships is attached.

An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

Health System Capacity Indicators provide additional surveillance measures that contribute to the development and targeting of services and the evaluation of MCH-related policies and programs. These indicators also provide guidance to collaborative efforts with other agencies and organizations to improve access to quality and timely health care.

Over the past few years improvement in access to surveillance data on a regular and basis has been a priority for the OFHS. As a result of funding from the State Systems Development Initiative Grant (SSDI) to support a MCH Epidemiologist, surveillance data is now updated on a regular basis. A Memorandum of Agreement (MOA) with Vital Records and the Center for Health Statistics provides all OFHS staff access to complete statistical data files on birth, death, fetal death, linked birth-infant death and intentional terminations of pregnancy. Through the development of the OFHS Data Mart, OFHS staff have access to standardized 1995-2005 vital records data and 1996-2005 hospital discharge data. Protocols are also in place to automatically append new data as it becomes available. Provisional data (monthly births and deaths; quarterly hospital discharges) and Census data are also included.

When available later in 2008, PRAMS data will become a part of the OFHS Data Mart. The PRAMS data will enable Virginia to better understand factors that may contribute to differential pregnancy outcomes.

/2009/ OFHS was awarded a 5 year CDC Assessment Initiative Project grant to enhance community health assessment activities in the central office and the 35 district health departments. //2009//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	42.2	36.6	32.2	31.6	29.6
Numerator	2072	1826	1653	1607	
Denominator	491229	498386	513018	508965	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

Data for 2007 not yet available. Entry is an estimate based on trend.

Notes - 2006

2006 Virginia hospital discharge data. Denominator from 2006 NCHS population estimates.

Notes - 2005

2005 Virginia hospital discharge data. Denominator from 2005 NCHS population estimates.

An attachment is included in this section.

Narrative:
Asthma is considered an ambulatory sensitive condition for which hospitalizations can be largely prevented with consistent, available ambulatory care and adherence to treatment/self-care protocols. Hospital admissions may indicate access issues such as lack of insurance or few other options for service or the presence of social issues that may influence patient/family care such as homelessness or inconsistent caregivers. In 1998 39.7 /10,000 children were hospitalized for asthma. In 2002, the rate was 38.6/10,000 and in 2003 the rate was 42.2/10,000 and 36.6/10,00 in 2004. The most recent rate (2005) is 32.2/10,000. If hospitalizations for this condition had been prevented substantial saving would have resulted. In 2004, 9,460 asthma hospitalizations occurred with associated costs totaling over $96 million. However, the data does not present a complete picture of the impact of asthma since the visits to emergency rooms is not captured unless the visit results in hospitalization. There are critical gaps in asthma related data. For example, Virginia does not have data on the number of children with asthma, where they are being treated, and if their treatment is in accordance with national guidelines. We know that asthma causes many missed school and work days, but do not have data to track these additional burdens for those living with asthma.

/2009/ There is a significant downward trend in asthma rates for children less than 5 years of age. The 2006 rate was 31.6/10,000. //2009//

Asthma hospitalization rates vary by age, gender and geographical areas of the state. In 2004, 16 of the 35 health districts had asthma hospitalization rates higher than the state rate. The districts with the highest rates included: Richmond City (33.4), Cumberland Plateau (29.2), Crater (27.4), Piedmont (24.4), Portsmouth (24.1), and Roanoke (20.2) per 10,000.

The Virginia Asthma Control Project (VACP) was created by the Virginia Department of Health in 2001 to reduce the increasing burden of asthma in the Commonwealth. The VACP is funded by the Centers for Disease Control and Prevention (CDC) and administered by the Office of Family Health Services' Division of Chronic Disease Control and Prevention. The goal of the VACP is to reduce the number of deaths, hospitalizations, emergency department visits, school or workdays missed, and limitations on activity due to asthma. The Virginia Asthma Coalition (VAC) consisting of seven regional coalitions works to improve asthma in the communities by promoting asthma awareness and prevention, asthma education, and the dissemination of asthma data. The VAC was created through collaboration between the Virginia Department of Health, the American Lung Association of Virginia and the Virginia Department of Education. The members include physicians, nurses, parents, health providers, governmental agencies, respiratory therapists and others who are concerned about controlling asthma.

Currently, the Virginia Behavior Risk Factor Surveillance System collects data on the prevalence of both adult and childhood asthma. In 2004, 17.8% of Virginia households with children reported that at least one child in the residence had asthma. The 2008 BRFSS will also include a call-back survey containing additional questions regarding adult asthma.

/2009/ In 2006 approximately 13.5% of Virginia children have been diagnosed with asthma at some point in their life and 8.6% of children currently have asthma. In 2006 Richmond City continued to have the highest rate of asthma hospitalizations at a rate of 385.6/100,000. The state average hospitalization rate was 123.5/100,000. //2009//

/2008/ On June 14, 2007 Lieutenant Governor Bolling and VDH announced the release of the first comprehensive data report on asthma. The Virginia Department of Health, Asthma Control Project, in conjunction with the Consortium for Infant and Child Health (a part of Eastern Virginia Medical School) will sponsor the Virginia Pediatric Asthma Conference on July 26, 2007. The conference is intended for statewide pediatricians and family practice physicians, residents, nurses, public health providers and other allied health professionals who work with children

affected by asthma. In addition, the first comprehensive data report on asthma was published. //2008//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	61.9	73.1	81.5	82.9	83.5
Numerator	44760	54980	32900	34387	35935
Denominator	72263	75209	40385	41493	43034
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data from the CMS 416 Report of Medicaid Eligible Recipients for Federal Fiscal Year 2007 (10/2006 - 9/2007) from DMAS.

Notes - 2006
Data from the CMS 416 Report of Medicaid Eligible Recipients for Federal Fiscal Year 2006 (10/2005 - 9/2006) from DMAS.

Notes - 2005
Data from the CMS 416 Report of Medicaid Eligible Recipients for Federal Fiscal Year 2006 (10/2004 - 9/2005) from DMAS.

An attachment is included in this section.

Narrative:
The Department of Medical Assistance Services (DMAS) has continued its renewed emphasis on maternal and child health services. Through agency reorganization, the department established the Division of Maternal and Child Health that is devoted exclusively to the management of such services within the Medicaid and SCHIP populations. In FY 05, DMAS conducted statewide provider trainings on the EPSDT program and on the necessity to conduct proper screenings. DMAS also conducts quarterly case manager meetings throughout the state. These meetings provide a valuable forum to discuss services to children. In addition, a partnership between DMAS and the VDH Lead Safe Virginia Program allowed for the matching of blood lead test results with Medicaid recipients. Alert letters are now being sent to every child's primary care provider that had an elevated blood lead level. These letters serve as a physician reminder to conduct all other screenings as well. As a result, 82.9% of Medicaid enrollees less than one year old received at least one initial periodic screen in 2006.

VDH Title V staff continues to participate with the Children's Health Insurance Advisory Committee. This Committee is now under private sector leadership and has formalized its purpose and objectives concerning outreach, enrollment and service improvement. This committee's goal is to improve the system's capacity to serve Virginia's children.

A web-based curriculum on Bright Futures and EPSDT for health care providers and other child-serving professionals has been developed and is now available at www.vcu-cme.org/bf .

/2008/ The Virginia Department of Medical Assistance Services (Medicaid), in partnership with VDH/Title V and the Virginia Chapter of the American Academy of Pediatrics (AAP) applied for participation in the ABCD Screening Academy sponsored by the National Academy for State Health Policy (NASHP). In April, Virginia was selected for participation in this 15-month long technical assistance project to increase use of standardized tools for developmental screening in early childhood. A team including representatives from the partner organizations will attend the ABCD Academy in July, and will be benefiting from the expertise of previous ABCD participants over the next year. Several primary care practices have been identified as pilot sites for intensive quality improvement efforts and measurement. The Virginia application was recognized for demonstrating strong collaboration between VDH, Medicaid and the AAP, for linking the ABCD project to existing plans, and for integration of Bright Futures and medical home concepts into efforts to increase EPSDT services. Virginia also recently applied for MCHB-HRSA Technical Assistance Project - State Leadership Workshops on Title V and Medicaid Collaboration to Improve EPSDT and Child Health. //2008//

/2009/ The percent of Medicaid enrollees who are less than one year of age that received at least one periodic screen continues to increase. The ABCD project has resulted in greater use of standardized tools for developmental screening and a steady increase of the number of medicaid paid claims for developmental screening. In January 2008 VDH Title V partnered with the Department of Medical Assistance Services to hold a two-day workshop on partnering to improve use of EPSDT services. MCHB and Johnson Consulting Group staff facilitated the discussion which resulted in a series of priorities: provider education; parent empowerment; mental health system capacity; statewide spread of developmental screening; fostering a stronger referral system. As a result of the ABCD project, the Piedmont Health District is piloting the use of the Ages and Stages Questionnaire in WIC clinics and two pediatric practices are preparing to pilot the use of a standardized developmental screening tool at the 9 month, 18 month, 24 month, and 48 month well child visits. //2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	52.3	55.1	54.6	61.4	41.4
Numerator	2486	3170	849	992	729
Denominator	4756	5750	1554	1615	1762
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data from SCHIP program, DMAS.

Notes - 2006
Data from SCHIP program, DMAS.

Notes - 2005
Data from SCHIP program, DMAS.

An attachment is included in this section.

Narrative:
The Department of Medical Assistance Services (DMAS) has continued its renewed emphasis on maternal and child health services. Through agency reorganization, the department established the Division of Maternal and Child Health that is devoted exclusively to the management of such services within the Medicaid and SCHIP populations. In FY 05, DMAS conducted statewide provider trainings on the EPSDT program and on the necessity to conduct proper screenings. DMAS also conducts quarterly case manager meetings throughout the state. These meetings provide a valuable forum to discuss services to children. In addition, a partnership between DMAS and the VDH Lead Safe Virginia Program allowed for the matching of blood lead test results with Medicaid recipients. Alert letters are now being sent to every child's primary care provider that had an elevated blood lead level. These letters serve as a physician reminder to conduct all other screenings as well. As a result of DMAS's continued efforts, the percent of FAMIS enrolled children less than one year old increased to 61.4% in 2006.

VDH Title V staff continues to participate with the Children's Health Insurance Advisory Committee. This Committee is now under private sector leadership and has formalized its purpose and objectives concerning outreach, enrollment and service improvement. This committee's goal is to improve the system's capacity to serve Virginia's children.

A web-based curriculum on Bright Futures and EPSDT for health care providers and other child-serving professionals has been developed and is now available at www.vcu-cme.org/bf .

/2008/ See Health Status Indicator 2 for information on Virginia's participation in the ABCD Screening Academy and Virginia's application for the MCHB-HRSA Technical Assistance Project - State Leadership Workshops on Title V and Medicaid Collaboration to Improve EPSDT and Child Health //2008//

/2009/ The ABCD project has resulted in a greater use of standardized tools for developmental screening. In January 2008 VDH Title V partnered with the Department of Medical Assistance Services to hold a two-day workshop on partnering to improve use of EPSDT services. MCHB and Johnson Consulting Group staff facilitated the discussion which resulted in a series of priorities: provider education; parent empowerment; mental health system capacity; statewide spread of developmental screening; fostering a stronger referral system. //2009//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	80.1	79.6	78.7	76.9	77.0
Numerator	80174	82429	81937	81647	81132
Denominator	100038	103505	104146	106146	105349
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
2007 data from provisional birth certificates.

Notes - 2006
2006 data from birth certificates.

Notes - 2005
2005 data from birth certificates.

An attachment is included in this section.

Narrative:
Birth certificate data are used to calculate the adequacy of prenatal care based on the Kotlechuck Index. The percentage of women receiving adequate prenatal care has remained fairly constant. In 2005, 78.7% of Virginia mothers received adequate prenatal care. Although almost 80% of received adequate care, there are racial and ethnic disparities. In 2005, 83.9% of white non-Hispanic women had adequate prenatal care while 75.3% of black non-Hispanic and 61.5% of Hispanic women had adequate care.

The Virginia Department of Health continues to provide Title V funding to support local health departments' perinatal services. These services range from pregnancy testing and referral to prenatal care providers to direct prenatal care including case management. This year approximately $3.5 million will be provided to the local health departments for perinatal services. In addition, services to ensure adequate prenatal care are also provided by the Resource Mothers program, a home visiting program for pregnant teens, and the Virginia Healthy Start Initiative. Seven Regional Perinatal Councils (RPCs) are funded to address issues relating to access to prenatal care, and to provide perinatal outreach education and to collect and review fetal/infant mortality data at the local level. In FY 05, the Regional Perinatal Councils trained a total of 17,446 professionals in obstetrical (355), neonatal (378) and other programs (184) totaling over 1461 program hours. Most were nurses (4,423) and respiratory therapists and consumers (10,509), while others were physicians (1,207), health educators (861), social workers (141), resource mothers (228), and nutritionists (77).

/2008/ In FY 06, the 7 RPCs trained 11,708 professionals in obstetrical (319), neonatal (362) and other programs (193). //2008//

/2009/ In FY 07, the 7 Regional Perinatal Councils trained a total of 7,050 professionals in obstetrical (218), neonatal (242), and other programs (113), totaling over 1,693 hours. Most were nurses (2,928), and respiratory therapists and consumers (2,656), while others were physicians (923), health educators (107), social workers (126), resource mothers (220), and nutritionists (90). //2009//

The State Maternal Mortality Review Team reviews deaths to determine the causes and circumstances in order to develop recommendations for prevention, education, training and system changes. Title V also provides partial support for the Pregnancy Risk Assessment Monitoring System (PRAMS) a survey to obtain information regarding pregnancy experience and outcomes from a sample of new mothers.

/2008/ Title V funds continue to support the work of the State Maternal Mortality Review Team and the State Child Fatality Review Team. The Maternal Mortality Review Team reviews all deaths to women within one year of the end of their pregnancy, whether that pregnancy ended with a termination, a fetal death, or a live birth. Preliminary information suggests that roughly

one-half of these deaths are from natural causes, and the other one-half are violent deaths attributed to homicide, suicide and unintentional injuries. A draft report covering the pregnancy-associated deaths from 1999-2001 has been prepared. The full report with recommendations will be available later this year. //2008//

/2009/ According to the 2006 birth certificate data there is a continued decreasing trend in the percent of women who have adequate prenatal care as measured by the Kotelchuck Index (76.9 percent of all women had adequate prenatal care). As in previous years, the percentage of black non-Hispanic and Hispanic women with adequate care is less than white non-Hispanic women (white non-Hispanic with adequate prenatal care was 82.4 % vs. black non-Hispanic, 75% and Hispanic, 59.4%). In the future, PRAMS may provide information on the reasons and suggest some potential strategies to increase the number of women receiving adequate prenatal care. //2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	86.0	77.6	79.0	80.0	78.5
Numerator	407845	435993	469480	489997	482835
Denominator	474478	561871	593915	612865	614904
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Numerator = Number of Annual Unduplicated Recipients from Statistical Record of VA Medicaid Program FY2007 Edition, page 3-3, total for 0-20 yr old.

Denominator = Number of Annual Unduplicated Individuals eligible for Medicaid Services from Statistical Record of VA Medicaid Program FY2007 Edition, page 2-12, total for 0-20 yr old + an estimate of the number of uninsured children who are eligible for Medicaid but not enrolled from DMAS (96,000).

Notes - 2006
Numerator = Number of Annual Unduplicated Recipients from Statistical Record of VA Medicaid Program FY2006 Edition, page 3-3, total for 0-20 yr old.

Denominator = Number of Annual Unduplicated Individuals eligible for Medicaid Services from Statistical Record of VA Medicaid Program FY2006 Edition, page 2-12, total for 0-20 yr old + an estimate of the number of uninsured children who are eligible for Medicaid but not enrolled from DMAS (96,000).

Notes - 2005
Numerator = Number of Annual Unduplicated Recipients from Statistical Record of VA Medicaid Program FY2005 Edition, page 3-3, total for 0-20 yr old.

Denominator = Number of Annual Unduplicated Individuals eligible for Medicaid Services from

Statistical Record of VA Medicaid Program FY2005 Edition, page 2-12, total for 0-20 yr old. Denominator revised for 2008 application to reflect a better estimate of the number of uninsured children who are eligible for Medicaid but not enrolled from DMAS. (96,000 added to denominator)

An attachment is included in this section.

Narrative:
DMAS undertook an aggressive campaign to enroll potential eligibles in both FAMIS and the rebranded Medicaid product, FAMIS Plus. FAMIS enrollment improved to where it is currently estimated that 92% of potential eligibles are enrolled. A strong network of community coalitions continues to work towards enrollment gains.

Virginia's Title V and Medicaid programs have a strong history of working together on a number of issues to improve child health services and EPSDT. An interagency agreement has been in place for many years that specifically addresses mutual support for promotion and delivery of EPSDT services, data sharing regarding lead screening and follow up, and provision of services under the BabyCare program. In addition, staff work collaboratively on numerous projects and programs to improve child health and well being including the adoption of Bright Futures as a standard of child health care in the Commonwealth, conducting joint trainings, providing program updates, and to enhance enrollment in Medicaid and SCHIP. Most notably, Title V and Medicaid staff worked together to simplify the Medicaid/SCHIP enrollment process. Title V facilitated having the single application embedded in the encounter system used by local health districts so that families with eligible children can be assisted with enrollment. Currently five local health districts use dedicated Title V funds to actively support Medicaid enrollment efforts.

VDH provides an administrative practice management system for the local health departments. An additional feature was recently added to the system that facilitates the Medicaid eligibility process. VDH and DMAS collect similar demographic information on clients for each organization's business purposes. Now, the VDH information will automatically populate the Medicaid Enrollment form and therefore allow staff to deliver billable services on the day the client has presented. For example, applications for infants that present to the health department for postpartum follow-up can immediately apply for Medicaid, and if approved, coverage is retroactive for three months.

A web-based curriculum on Bright Futures and EPSDT for health care providers and other child-serving professionals has been developed and is now available at www.vcu-cme.org/bf .

/2008/ Title V and Medicaid continue to work jointly to increase eligible children's enrollment in Medicaid/SCHIP. See Health Status Indicator 5B for information regarding Title V funding for local health departments' perinatal services, Resource Mothers, Virginia Healthy Start Initiative and the Regional Perinatal Councils. See Health Status Indicator 2 for information on Virginia's participation in the ABCD Screening Academy and Virginia's application for the MCHB-HRSA Technical Assistance Project - State Leadership Workshops on Title V and Medicaid Collaboration to Improve EPSDT and Child Health //2008//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	24.9	32.8	35.1	45.6	51.5
Numerator	21909	30132	35184	47991	55232
Denominator	87816	91991	100223	105176	107237

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
Data from Federal Fiscal Year 2007 (10/2005 - 9/2006) from DMAS.

Notes - 2006
Data from the CMS 416 Report of Medicaid Eligible Recipients for Federal Fiscal Year 2006 (10/2005 - 9/2006) from DMAS.

Notes - 2005
Data from the CMS 416 Report of Medicaid Eligible Recipients for Federal Fiscal Year 2006 (10/2004 - 9/2005) from DMAS.

An attachment is included in this section.

Narrative:
In 2004, 32.8 percent of EPSDT eligible children aged 6 through 9 years have received dental services during the year. This represents a small improvement over the 28.0 percent reported in 2000. One ongoing dental health care issue is the lack of Medicaid dental providers. This may be one factor in the low percent of EPSDT eligible children receiving dental care. During the past few months for profit dental practice franchises have opened in some areas of the state. These dental practices (Kool Smiles and Small Smiles) specifically target services to Medicaid eligible children. Depending on the success of these franchises, the percent of children receiving Medicaid reimbursed dental care should increase in areas where the services are available.

It is anticipated that recent changes in how dental services are administered by the Department of Medical Assistance Services (the Medicaid agency) will also have an impact on the number of children receiving dental care. Prior to July 1, 2005, dental services were administered through the fee-for-service and MCO programs. Approximately 70% of children were enrolled in MCOs and the remaining were enrolled in fee-for-service programs. The dentists complained that the program was administratively cumbersome. As a result, Medicaid/FAMIS dental services were carved out of the MCO programs and consolidated with the fee-for-service program and administered as a single statewide program. On July 1, 2005, the Smiles for Children program was implemented. Doral Dental USA, LLC was chosen to administer the Smiles for Children program. The new program also includes an overall increase in dental fees of 30%, as approved by the 2005 Virginia General Assembly and a member outreach and education component to increase children's dental utilization. Additionally, the Medicaid program actively recruits dentists. During the past year the number of Medicaid dental providers has increased from 620 to 810, a 31% increase.

/2008/ The changes in how dental services are administered have resulted in a significant increase in the percent of EPSDT eligible children who have received a dental service. //2008//

Virginia participated along with 14 other states in the Center for Health Care Strategies Purchasing Institute: Best Practices for Oral Health Access program. The Institute, partially funded by the Robert Wood Johnson Foundation, took place in September 2005 in Philadelphia. David Suttle, MD and Karen Day, DDS for Virginia's Title V program participated as team members, along with representatives from the Medicaid agency.

Dr. Karen Day, director of the Virginia Department of Health's Division of Dental Health,

participates on the state Dental Advisory Committee.

Beginning in state FY 2006, the Governor and General Assembly approved $325,000 for dental scholarships and loans to increase the number of dentists working in underserved areas of the state. The Virginia Department of Health's Division of Dental Health administers the dental scholarship and loan repayment program. In FY 2006, 17 scholarships and 7 loans were issued to dental students and practicing dentists. A requirement of the scholarship and loan programs is that the dentist must practice in an underserved area and agree to serve Medicaid patients. It is anticipated that the program requirements will increase the number of dentist serving Medicaid/FAMIS children.

/2009/ In FY08, the dental hygienist loan repayment program, which has similar requirements regarding Medicaid, was added. There are 13 dental hygienists and 20 dentists receiving scholarships and loan repayments this year. The Department of Medical Assistance Services is reporting more than 1,000 dentists participating in the Smiles for Children program, which has resulted in increasing numbers of children accessing dental services. //2009//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	3.3	2.6	2.8	2.9	3.3
Numerator	571	468	535	563	644
Denominator	17474	18020	18832	19205	19500
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

An attachment is included in this section.

Narrative:
In FY 06, 2.9 percent of Virginia's SSI beneficiaries less than 16 years old received rehabilitation services from the CSHCN Program. This is higher than the 2005 level of 2.8 percent. From 2001 through 2004 the percentage dropped as the model of care for Virginia Title V CSHCN program for persons with physical disabilities transitioned from the provision of direct care in clinics to intensive care coordination. Now a broader range of children with varying financial circumstances and diagnoses are being served. Since 2004 there has been a steady increase in the percentage of SSI beneficiaries being served. The percent of SSI clients to total clients, less than 16 years old, is 15.5 percent in the Care Connection for Children Centers and 7.5 percent in the Bleeding Disorders Program. Due to the type of diagnoses served in the Child Development Clinics the percentage is much lower at 3.9 percent. All of these CSHCN programs continue to provide outreach to potentially eligible families and coordination of services for those eligible for SSI. This is a major component of the scope of services in the contracts with the local entities managing these programs.

/2009/ The percent of state SSI beneficiaries has continued to increase from 2004 (2.6%) to 2007 (3.3%), however this increase is not statistically significant. From 2006 to 2007, the percent of SSI clients to total clients, less than 16 years old, continued to have small increases per CSHCN program with 15.5% to 15.8% for Care Connection for Children Centers and 7.5% to 8.8% for the Bleeding Disorders Program. The Child Development Clinics had the highest percentage increase from 3.9% in 2006 to 9.8% in 2007. This continues to be a major component of the scope of services in contracts with local entities managing these programs. //2009//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2006	payment source from birth certificate	10.4	7.5	8.2

Notes - 2009
Data from 2006 Birth certificates.

An attachment is included in this section.

Narrative:
The data source for expected payment source comes directly from the birth certificate data.

In 2005, 8.1% of all Virginia births were low birthweight with births covered by Medicaid having a higher percent of low birthweight births (10.3% as compared to 7.4% for non-Medicaid) and a higher rate of infant deaths (10.2 vs. 5.8 per 1000 live births). Also Medicaid births compared to non-Medicaid births had a lower percent of early entry into prenatal care (73% vs. 88.2%) and adequate prenatal care (68.9% vs. 81.7%).

/2009/ In 2006, 8.2% of all Virginia births were low birthweight with births covered by Medicaid having a higher percent of low birthweight births (10.2% as compared to 7.5% for non-Medicaid births). Medicaid births continued to have a lower percent of early prenatal care (72.6% as compared to non-Medicaid 87.2) and a lower percent of adequate prenatal care (69% as compared to 79.6% of non-Medicaid). These percentages remain similar to the previous year. //2009//

The Virginia Department of Health continues to provide Title V funding to support local health departments' perinatal services. These services range from pregnancy testing and referral to prenatal care providers to direct prenatal care including case management. This year approximately $3.5 million will be provided to the local health departments for perinatal services. In addition, services to ensure adequate prenatal care are also provided by the Resource Mothers program, a home visiting program for pregnant teens, and the Virginia Healthy Start Initiative. Seven Regional Perinatal Councils (RPCs) are funded to address issues relating to access to prenatal care, and to provide perinatal outreach education and to collect and review fetal/infant mortality data at the local level.

/2008/ In FY 06, the 7 RPCs trained 11,708 professionals in obstetrical (319), neonatal (362) and other programs (193). //2008//

/2009/ See Health System Capacity Indicator # 4 for information on the Regional Perinatal trainings for FY07. //2009//

/2008/ The Governor's New Parent Kit continues to be distributed with an emphasis on increasing prenatal distribution. The kit contains information from the March of Dimes regarding signs of preterm labor. //2008//

In 2006 Virginia was awarded funds from the Centers for Disease Control to implement the Pregnancy Risk Assessment Monitoring System (PRAMS). Title V also provides partial support. PRAMS will obtain information regarding pregnancy experience and outcomes from a sample of new mothers. Low birthweight births will be over sampled. The project will also enable Virginia to look more closely at the Medicaid vs. non-Medicaid births and better understand factors that may contribute to differences in entry to prenatal care and pregnancy outcomes.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	matching data files	9.1	5.4	7.1

Notes - 2009
Data from 2006 infant death certificates linked to birth certificates.

An attachment is included in this section.

Narrative:
The data source for expected payment source comes directly from the birth certificate data.

In 2004, 8.2% of all Virginia births were low birthweight with births covered by Medicaid having a higher percent of low birthweight births (10.5% as compared to 7.5% for non-Medicaid) and a higher rate of infant deaths (9.9 vs. 6.1 per 1000 live births). Also Medicaid births compared to non-Medicaid births had a lower percent of early entry into prenatal care (74.2% vs. 88.5%) and adequate prenatal care (71.1% vs. 82.8%). The differences in outcomes continued for Medicaid and non-Medicaid births in 2005. In 2005, 8.1% of all Virginia births were low birthweight with births covered by Medicaid having a higher percent of low birthweight births (10.3% as compared to 7.4% for non-Medicaid) and a higher rate of infant deaths (10.2 vs. 5.8 per 1000 live births). Also Medicaid births compared to non-Medicaid births had a lower percent of early entry into prenatal care (73% vs. 88.2%) and adequate prenatal care (68.9% vs. 81.7%).

The State Maternal Mortality Review Team reviews deaths to determine the causes and circumstances in order to develop recommendations for prevention, education, training and system changes.

/2008/ See Health Status Indicator 5A for information regarding Title V funding for local health departments' perinatal services, Resource Mothers, Virginia Healthy Start Initiative and the Regional Perinatal Councils. //2008//

/2009/ See Health System Capacity Indicator # 4 for information on the Regional Perinatal

trainings for FY07. //2009//

/2008/ The newly implemented PRAMS project will enable Virginia to look more closely at the differences between the Medicaid vs. non-Medicaid births and better understand factors that may contribute to differences in entry to prenatal care and pregnancy outcomes. //2008//

/2008/ The Health Reform Commission contained recommendations to decrease infant mortality and provide prenatal care to more pregnant women. These include:

--The Governor should recommend increasing FAMIS/Medicaid insurance for pregnant women from 185 percent FPL to 200 percent FPL;
--The Governor should provide the Board of Health with the authority in the Code of Virginia to develop criteria to identify and establish perinatal underserved areas;
--The Governor should, through DMAS and VDH, promote one screening tool for pregnant women for all publicly-funded programs and should make training available to all providers;
--The Governor should provide additional funding to effective prenatal home visiting programs that meet those criteria established for publicly funded home visiting;
--The Governor should provide funding to develop, evaluate and replicate intensive evidence-based interconception care and care coordination models for women at high social and medical risk;
--The Governor should provide funding to educate parents and providers regarding SIDS and safe sleeping environments. //2008//

/2009/ The differences in outcomes continued for Medicaid and non-Medicaid births in 2006. In 2006, 8.2% of all Virginia births were low birthweight with births covered by Medicaid having a higher percent of low birthweight births (10.4% as compared to 7.5% for non-Medicaid) and a higher rate of infant deaths (9.1 vs. 5.4 per 1000 live births). Also Medicaid births compared to non-Medicaid births had a lower percent of early entry into prenatal care (72.6% vs. 87.2%) and adequate prenatal care (69% vs. 79.6%). //2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	payment source from birth certificate	72.6	87.2	83.5

Notes - 2009
Data from 2006 Birth certificates.

An attachment is included in this section.

Narrative:
The data sources for this Health Systems Capacity Indicator are the expected payment source identified on the birth certificate and the adequacy of prenatal care as measured by the Kotelchuck Index. The overall percentage of women receiving adequate prenatal care has remained constant with the exception of an increase to 86.2% in 2003. The 2003 data represents

a calculation error. The corrected 2003 data show that 80.1% of women received adequate prenatal care. This calculation error was also reflected in the 2003 data on the difference in Medicaid and non-Medicaid adequacy of care reported last year. In 2004, approximately 80% of Virginia mothers received adequate prenatal care. Although almost 80% of received adequate care there are racial and ethnic disparities. In 2004, 84.4% of white non-Hispanic women had adequate prenatal care while 75.2% of black non-Hispanic and 64.2% of Hispanic women had adequate care. There is also a difference in Medicaid and non-Medicaid with a lower percentage of Medicaid patients receiving adequate prenatal care (71.1% vs. 82.8% non-Medicaid births).

/2008/ In 2005, the percent of infants born to women who received early prenatal care was 84.6%. The largest increase was in the infants born to the non-Medicaid women. Entry into prenatal care continued to vary by race and ethnicity (white non-Hispanic, 89.8%; black, non-Hispanic, 79.8%; and Hispanic 72.7%). //2008//

Hispanic women, compared to both white non-Hispanic and black non-Hispanic, are less likely to enter prenatal care during the first trimester. In 2004, approximately 72% of Hispanic women received prenatal care beginning in the first trimester and 64% received adequate prenatal care. Immigration status may a play role in early and adequate prenatal care and may impact the percent of Medicaid women who have adequate prenatal care. Further analysis on the impact of immigration status on early entry into prenatal care and the adequacy of prenatal care would be beneficial.

/2008/ See Health Status Indicator 5A for information regarding Title V funding for local health departments' perinatal services, Resource Mothers, Virginia Healthy Start Initiative and the Regional Perinatal Councils. //2008//

/2009/ In 2006, 83.5 percent of all women giving birth received prenatal care in the first trimester. First trimester entry into prenatal care continued to vary by race and ethnicity (white non-Hispanic, 88.6%; black non-Hispanic, 79.2%; and Hispanic 68.8%). //2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	payment source from birth certificate	69	79.6	76.9

Notes - 2009
Data from 2006 Birth certificates.

An attachment is included in this section.

Narrative:

The data sources for this Health Systems Capacity Indicator are the expected payment source identified on the birth certificate and the adequacy of prenatal care as measured by the Kotelchuck Index. The overall percentage of women receiving adequate prenatal care has remained constant with the exception of an increase to 86.2% in 2003. The 2003 data represents a calculation error. The corrected 2003 data show that 80.1% of women received adequate prenatal care. This calculation error was also reflected in the 2003 data on the difference in Medicaid and non-Medicaid adequacy of care reported last year. In 2004, approximately 80% of Virginia mothers received adequate prenatal care. Although almost 80% of received adequate care there are racial and ethnic disparities. In 2004, 84.4% of white non-Hispanic women had adequate prenatal care while 75.2% of black non-Hispanic and 64.2% of Hispanic women had adequate care. There is also a difference in Medicaid and non-Medicaid with a lower percentage of Medicaid patients receiving adequate prenatal care (71.1% vs. 82.8% non-Medicaid births).

/2008/ In 2005, 83.9% of white non-Hispanic women received adequate prenatal care while 75.3% of black non-Hispanic and 61.5% of Hispanic women had adequate care. There is also a difference between Medicaid and non-Medicaid with a lower percentage of Medicaid patients receiving adequate prenatal care (68.9% vs. 81.7% non-Medicaid births). //2008//

Hispanic women, compared to both white non-Hispanic and black non-Hispanic, are less likely to enter prenatal care during the first trimester. In 2004, approximately 72% of Hispanic women received prenatal care beginning in the first trimester and 64% received adequate prenatal care. Immigration status may play role in early and adequate prenatal care and may impact the percent of Medicaid women who have adequate prenatal care. Further analysis on the impact of immigration status on early entry into prenatal care and the adequacy of prenatal care would be beneficial.

/2008/ See Health Status Indicator 5A for information regarding Title V funding for local health departments' perinatal services, Resource Mothers, Virginia Healthy Start Initiative and the Regional Perinatal Councils. //2008//

/2008/ The newly implemented PRAMS project will enable Virginia to look more closely at the differences between the Medicaid vs. non-Medicaid births and better understand factors that may contribute to differences in entry to prenatal care and pregnancy outcomes. //2008//

/2009/ In 2006, 76.9 percent of all women giving birth received adequate prenatal care. The percent of pregnant women with adequate prenatal care continued to vary by race and ethnicity (white non-Hispanic, 82.4%; black non-Hispanic, 75%; and Hispanic 59.4%). //2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	200

Narrative:
The percent of the federal poverty level for eligibility in Virginia's Medicaid programs for infants remains unchanged at 133% FPL.

The percent of the federal poverty level for eligibility in Virginia's SCHIP (FAMIS) program also remains unchanged at 200% FPL.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	200

Narrative:
The percent of the federal poverty level for eligibility in Virginia's Medicaid programs for children remains unchanged at 133% FPL.

The percent of the federal poverty level for eligibility in Virginia's SCHIP (FAMIS) program also remains unchanged at 200% FPL.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2007	185

Notes - 2009
The eligibility for the FAMIS-MOMS program increased to 185% FPL effective July 1, 2007.

Narrative:
The percent of the federal poverty level for eligibility in Virginia's Medicaid programs for pregnant women remains unchanged at 133% FPL.

Effective July 1, 2007, the percent of the federal poverty level for eligibility in Virginia's SCHIP (FAMIS-MOMS) program is 185% FPL.

/2009/ Effective July 2009 the percent of the federal poverty level for eligibility in Virginia's FAMIS-MOMS will increase to 200%. //2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	1	No
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009
An attachment is included in this section.

Narrative:
The Virginia State Systems Development Initiative (SSDI) funds portions of the MCH Epidemiologist and the MCH Lead Analyst positions, which serve as SSDI Director and Coordinator, respectively. A major focus of the grant is to develop and maintain an MCH Data Mart that facilitates access to timely and accurate surveillance data which are updated as new data are released. Office of Family Health Services staff have electronic access to birth certificate and infant death data, which are linked on an annual basis. Direct electronic access is also provided to the birth defects and hearing screening surveillance systems. Direct access to WIC data is available and limited work has begun to link WIC and birth certificate data.

Currently, VDH has access to Medicaid eligibility files for local health department clinics to determine Medicaid status. An agreement has been signed to allow VDH to receive Medicaid

claims data and link it to birth certificate data for the purpose of evaluating a recently expanded Medicaid family planning waiver.

A linkage between the birth certificate and the newborn screening files does not currently exist, but is under development.

Complete hospital survey data are not available in Virginia. Virginia does routinely analyze the available inpatient hospital discharge data to determine the reasons for hospitalizations as well as the related charges. Virginia is one of nine new PRAMS states effective April 14, 2006. Following an initial planning year, the first complete year of data is expected to be weighted and available for analysis in October 2008. Virginia PRAMS addresses current data gaps in areas including intendedness of pregnancy, risk behaviors during pregnancy, and postpartum depression.

/2008/ Michelle White was hired as the PRAMS Coordinator. The Virginia PRAMS protocol has been developed and the first PRAMS mailings have been completed. VCU's Survey and Evaluation Research Lab (SERL) has been contracted to serve as the PRAMS Data Manager.

The data available in the OFHS Data Mart continue to expand. The most recent addition includes the hospital discharge data. The BRFSS data will be added in the near future.

Caroline Stampfel, a CSTE fellow, was hired to serve as a MCH Epidemiologist. A new CSTE fellow has been assigned to Virginia for two years. Andrea Alvarez will begin her fellowship in August. //2008//

/2009/ The MCH Data Mart has expanded to include regular monthly access to newborn screening data and provisional birth and death certificate data. Data linkages tested this year included a birth to birth mother-centered linkage to establish interpregnancy interval and conduct surveillance and research activities around birth spacing. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Virginia Youth Tobacco Survey	2	No

Notes - 2009

The Virginia Department of Health received CDC funding for YRBS in March 2008. The Virginia Youth Survey Coordinator (YRBS) position is currently in recruit. The survey will be implemented in 2009. Once the survey is implemented the MCH program will have direct access to the state YRBS database for analysis.

Narrative:

Virginia does not participate in the Youth Risk Behavior Survey (YRBS). Some school districts however, do conduct the YRBS or a partial YRBS-type survey. This limits the MCH program's ability to obtain data on a number of youth risk behaviors including obesity and the use of tobacco products. The Youth Tobacco Survey (YTS), was conducted in 2001, 2003 and 2005. The 2003 survey showed a 28 percent decrease in the number of high school students and a 45 percent decrease in the number of middle school students that report that they currently smoke.

/2008/ The Virginia Youth Tobacco Survey was conducted in the fall of 2005. The proportion of students reporting having ever used any tobacco products has fallen from 56% in 2001 to 45% in 2005. Twenty-seven percent of high school students and 12% of middle school students reported that they currently use a tobacco product. //2008//

The Virginia Tobacco Settlement Foundation (VTSF) funded 95 agencies to conduct prevention and/or smoking cessation programs throughout Virginia. The VTSF also released 3 additional television commercials and radio spots and trained a total of 500 high school students who will work with youth to increase awareness of smoking effects.

The Virginia Tobacco Use Control Project (TUCP)within the Virginia Department of Health is funded through a grant from the Centers for Disease Control and Prevention's Office on Smoking and Health. The TUCP provides training, information and materials to support the implementation of policies to help Virginians choose and maintain tobacco-free lifestyles. The TUCP works closely with coalitions, health districts and partner organizations to reduce youth tobacco use, increase cessation support, and increase clean indoor air.

/2008/ The Virginia's Community Youth Survey was conducted in 2005 on behalf of Virginia's Department of Mental Health, Mental Retardation and Substance Abuse Services. The survey was administered to a sample of 8th, 10th, and 12th grade public school students. Approximately 59% of the students indicated that they have consumed alcohol and approximately 38% indicated that they had smoked cigarettes. The report also includes information on the use of other drugs, protective factors, risk factors as well as regional differences. //2008//

The State Systems Development Initiative works closely with the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services, the Virginia Department of Education, the Virginia Tobacco Settlement Foundation and the Virginia Tobacco Use Control Project to obtain data on youth tobacco and drug use.

/2009/ The OFHS, working closely with the Department of Education, received CDC funding for the YRBS in March 2008. The Virginia Youth Survey (YRBS) will be administered in 2009. OFHS is currently recruiting for the coordinator's position. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

Virginia's Title V program continues to be challenged by changing economic, social, and political forces dramatically impacting the provision of health care. Although surveys have shown decreases in uninsured rates, rising health care costs and other market forces may slow those decreases particularly among lower income persons. Virginia's revised S-CHIP program, FAMIS, has been a major force in increasing the number of children who have insurance and access to health care. The changes in the FAMIS application process have also helped to identify and enroll more children in Medicaid, again increasing access to health care.

Managed care continues to be a major force in the health insurance area with half of all Medicaid recipients now under a managed care plan. The lack of providers has presented major problems in the Commonwealth. Like many other states, Virginia is experiencing what many people have referred to as a crisis in access to obstetrical care. The effects have been felt most in rural areas, but suburban and urban communities are also experiencing the effects. Several small community hospitals no longer provide obstetrical care and some obstetricians have stopped providing coverage for family practice physicians who have been delivering babies or have stopped providing supervision of certified nurse midwives. Some OB/GYNs have limited their practice to gynecology due to the prohibitive cost of malpractice insurance premiums. This has resulted in women having to travel further to the hospital or delivering in the emergency rooms or perhaps having inadequate prenatal care. The lack of dental providers also impacts children's access to dental care, especially for Medicaid children.

Communities continue to experience changing demographics with an influx of many new multicultural populations entering the state. Title V will prioritize efforts to address the needs of the most vulnerable populations. Market forces and recently enacted laws have forced public health, along with the Title V program, to reevaluate priorities, allocation of resources, and strategies used to achieve optimum health.

During the development of the 2006 Title V Block Grant application, the OFHS Management Team along with a number of our external partners, reviewed the Title V priorities, as well as needs assessment data that included the qualitative data from the key stakeholder interviews, focus groups, and the public hearings. The following reflects the priority areas that will be used to focus OFHS activities and resources during the coming years:

1. Exercise leadership in nurturing partnerships that promote systematic communication, coordination, shared resource allocation and education around health improvement efforts.

2. Enhance data collection and dissemination efforts to promote evidence-based decision making in planning, policy, evaluation, allocation and accountability.

3. Assess and develop strategies to address underinsurance for vulnerable populations to improve access to affordable, acceptable care.

4. Evaluate, coordinate and enhance provider education in risk assessment, documentation, intervention, treatment and referral consistent with evidence-based standards of care around health issues specific to women and children.

5. Advance a holistic continuum of care model for women's health services across the life-span toward improvements in health for women, their children and their families.

6. Expand availability, quality and utilization of medical homes for children.

7. Improve access to dental care, awareness of oral health, and application of new models in

dental health services.

8. Incorporate mental health into relevant preventive health efforts in MCH; participate in efforts to promote availability and quality of mental health services; and facilitate links between the mental health and health care communities.

9. Improve access to prenatal care including appropriate genetic assessment and breastfeeding support for all women across the state.

10. Apply socio-ecologic models to promote healthy weight by encouraging appropriate nutrition and safe physical activity efforts.

In addition to the 18 National Performance Measures, Virginia has identified state level performance measures that will enable the state to monitor progress related to the state MCH priorities. The State Performance Measures include the following:

1. The percent of children and adolescents who have a specific source of ongoing primary care for coordination of their preventive and episodic health care.
2. Percent of children who are overweight or obese.
3. Percent of newborns screened for hearing loss who receive recommended follow-up services.
4. The unintentional injury hospitalization rate for children 1-14 per 100,000.
5. Percent of low-income children (ages 0-5) with dental caries.
6. The number of dental providers practicing in underserved areas.
7. The proportion of children (0-21) who receive genetic testing.
8. Percent of women reporting substance use during pregnancy.
9. Percent of women with a on-going source of primary care.

State Outcome Measure:
1. The black-white low birth weight ratio among singleton live births.

/2008/ State Performance Measure 3 has been changed to: The percent of newborns who fail the hearing screeening and who receive a diagnosis before three months of age. This measure was updated for the 2008 Title V Application to reflect a commitment to achieving not just a follow-up visit but an actual diagnosis. //2008//

/2009/ No changes have been made to state performance measures or the state MCH priorities. //2009//

B. State Priorities

As part of the 2005 Five-Year Needs Assessment, Virginia developed ten statewide priorities. The following shows the relationship between Virginia's maternal and child health (MCH) priorities and specific measures that are required elements of the annual block grant report: national performance measures (NPM), national outcome measures (OM), state performance measures (SPM), state outcome measures (SOM), health systems capacity indicators (HSCI), and health status indicators (HSI). The priorities are not ranked. The issue of health disparities is a cross cutting issue that underlies each of the priorities.

Priority # 1: Exercise leadership in nurturing partnerships that promote systematic communication, coordination, shared resource allocation and education around health improvement efforts.

The key stakeholders identified the need for increased and improved communication, leadership and improved planning, resource development and sharing. The key stakeholders also identified the need to increase collaborative activities to address identified community needs especially as

they relate to health disparities. An overall theme identified in the CAST-5 assessment was the need for a greater leadership role in developing stronger, collaborative intra-agency and interagency systems of care that are focused on and organized around serving similar populations.

One of the most vulnerable populations, CSHCN, remains as a major priority, receiving a large proportion of Title V funds. Improving identification of "at-risk" populations and assuring linkages with prevention, early intervention, and family support services can only be successfully accomplished through the development and nurturing of partnerships that promote systematic communication, coordination, shared resource allocation and education around health improvement efforts.

NPM # 2, NPM # 5 and NPM # 7

Priority # 2: Enhance data collection and dissemination efforts to promote evidence-based decision making in planning, policy, evaluation, allocation and accountability.

Virginia will make enhancing data collection and dissemination a priority again this year. This year's needs assessment identified gaps in data for measuring health behaviors among pregnant women and adolescents specifically. The Virginia MCH program will continue to look for opportunities to partner with other agencies to collect data on youth risk behavior and will continue to advocate for Virginia's participation in the Youth Risk Behavior Surveillance System (YRBS). Virginia was recently awarded funding for the Pregnancy Risk Assessment Monitoring System (PRAMS). Both individual and organizational respondents to the needs assessment on-line survey indicated that the health department needed to ensure that health programs are working and needed to inform and educate the public and families about health issues and prevention. The key stakeholders expressed a desire for easily accessible data and the need to be informed about what data is available. The CAST-5 assessment identified the need for better data collection.

/2009/ Virginia was awarded CDC funding to implement the Virginia Youth Survey (YRBS) beginning in 2009. The availability of state level data on youth behavior will address a need identified in the 2005 needs assessment. //2009//

HSCI # 9a and 9b
Priority # 3: Assess and develop strategies to address underinsurance for vulnerable populations to improve access to affordable, acceptable care.

The key stakeholders indicated that there is a growing number of persons who are experiencing limited access to medical and dental care. The perinatal focus groups indicated that the greatest barrier for women receiving prenatal care was the lack of access to an affordable health care system in a timely manner. The on-line survey found that both individual and organizational representatives ranked the lack of health insurance coverage for children and women as the second major health issue. In 2004, 13 percent of Virginia women did not have health insurance. The percentage of children without health insurance in Virginia varies depending on the data source used, with a range between 7 percent and 14 percent. In addition, there is a growing concern about non-English speaking and immigrant women's and children's access to health related services, particularly linguistically and culturally appropriate services.

Additional efforts addressing this priority include referring patients to Medicaid and FAMIS and assisting CSHCN families in finding insurance (enabling services) and continuing to monitor the insurance status of the vulnerable populations (infrastructure building services). VDH participates in state level coalitions to define and measure underinsurance and consider policies to alleviate the problem.

NPM # 3, NPM # 4, NPM # 13, HSCI # 2, HSCI # 3, HSCI # 4, HSCI # 7A & 7B, SPM # 1, SPM #

2, SPM # 6, SPM # 9

Priority # 4: Evaluate, coordinate and enhance provider education in risk assessment, documentation, intervention, treatment and referral consistent with evidence-based standards of care around health issues specific to women and children.

In 2000-2002, unintentional injuries were the leading cause of deaths for persons aged 1 to 64. Unintentional injuries accounted for 52 percent of all deaths that occurred among persons aged 15 to 19. The majority of these deaths are preventable. In 2003, 57 intimate partner homicides occurred in Virginia. Nearly four of every five victims were women and three of the victims were children under the age of 18. There is also a need for continued efforts to promote healthy behaviors to reduce morbidity and mortality. Concerns relating to injury, violence, and obesity were identified in the needs assessment. The key stakeholders identified the need for expanded prevention and education services for children relating to health issues, and the need for increased education for the prevention of risky behaviors among adolescents. The on-line survey identified obesity, domestic violence and child abuse and neglect as major health related issues. The public hearings identified the need to improve training of health professionals in screening for and identifying violence and sexual abuse. Activities to address this priority include continuing population-based prevention education and provider training on the identification of violence and appropriate documentation and referral.

NPM # 10, NPM # 14, NPM # 16, SPM # 1, SPM # 4, HSI # 3 a- c, HSI # 4 a-c, SPM # 2, SPM # 2, HSI # 8a, 8b

Priority # 5: Advance a holistic continuum of care model for women's health services across the life-span toward improvements in health for women, their children and their families.

Stakeholders in the priority setting meeting discussed the importance of extending the concept of "medical home" to women to ensure that they have an ongoing source of care. Although the Title V focus is on children and women of childbearing age, taking a life-span holistic approach recognizes the importance of overall health and the impact that may have on pregnancy. Activities related to this priority include educating women on the importance of total health, the prevention of chronic diseases for themselves and their children, and educating providers on the importance of using preventive guidelines. Other activities include the promotion of aggressive management of chronic diseases such as diabetes during and after pregnancy, and promoting preconceptual and interconceptual health, especially as it relates to their baby's health once pregnant.

SPM # 9

Priority # 6: Expand availability, quality and utilization of medical homes for children.

Having a medical home has been identified as an important way to ensure that children and especially CSHCN receive the comprehensive care that they need. In the medical home concept a physician provides primary care that is easily accessible, family centered, coordinated, and culturally appropriate. In 2003, 54.5 percent of Virginia CSHCN and 75 percent of children and adolescents received coordinated, ongoing, comprehensive care within a medical home. The key stakeholders and the public hearing participants identified the need for increased access to care and the need for coordinated and culturally-appropriate care. Some activities related to this priority include collaborating with other community agencies and state level groups to expand the availability of medical homes (infrastructure building services) and working with families to ensure that children are referred to a medical home (enabling services).

NPM # 3, SPM # 1

Priority # 7: Improve access to dental care, awareness of oral health, and application of new

models in dental health services.

In 2000, the first Surgeon General's report on oral health identified a "silent epidemic" of dental and oral diseases that burdens some population groups. Oral diseases can place a major burden on low-income and underserved individuals in terms of pain, poor self-esteem, cost of treatment, and lost productivity from missed work or school days. Dental disease and access to dental care is a chronic problem among low-income populations in Virginia. In the public hearings, the need to increase access to dental services for women and children was identified. The lack of access to dental care was also a finding from the key stakeholder interviews and was identified as the most needed but not received service for children by respondents to the on-line survey. The Division of Dental Health's approach to this includes infrastructure building services such as oral health surveillance and recruitment of public health dentists. The Division also maintains a quality assurance program for public health dentists. Population-based services include dental education, community water fluoridation, and the fluoride mouth rinse and varnish program. A number of local health departments provide clinical dental services.

NPM # 9 and SPM # 5, SPM # 6, HSCI # 7B

Priority # 8: Incorporate mental health into relevant preventive health efforts in MCH; participate in efforts to promote availability and quality of mental health services and facilitate links between the mental health and health care communities.

The public hearing participants identified the need for greater access to mental health services for women and children. The key stakeholders indicated that mental health and substance abuse services are in short supply, especially for low-income women and children. The perinatal focus groups identified women with mental health or substance abuse problems as one of the sub-populations not receiving appropriate prenatal care. Both the individual and organizational respondents to the on-line survey identified behavioral health issues as the third highest health issue for children, and depression and mental illness as the third highest issue for women. Some of the proposed approaches to address this issue included raising public awareness of the impact of mental health on overall health and the importance of viewing mental health from a public health perspective. Other approachs include partnering with mental health and strengthening our Title V programs in addressing mental health related issues such as perinatal depression, suicide, substance abuse and eating disorders.

SPM # 8 and NPM # 15, NPM # 16

Priority # 9: Improve access to prenatal care including appropriate genetic assessment and breastfeeding support for all women across the state.

Overall, 85 percent of women begin prenatal care during the first trimester, however the rate varies by race and ethnicity. For example, in 2003, 71.1 percent of Hispanic women and 77.2 percent of Black women began prenatal care in the first trimester. Like many other states, Virginia is experiencing what many people have referred to as a crisis in access to obstetrical care. The effects have been felt most in rural areas. Several small community hospitals no longer provide obstetrical care and some obstetricians have stopped providing coverage for family practice physicians who have been delivering babies or have stopped providing supervision of certified nurse midwives. This has resulted in women having to travel further to the hospital or delivering their babies in emergency rooms. The key stakeholders identified access to obstetrical and other perinatal services as scarce for the generally low-income population and for rural and minority residents. The perinatal focus groups indicated that the availability of prenatal care varies from locality to locality and differs widely by demographic group and access to a payment source. The on-line survey respondents identified the lack of prenatal care as being one of the top five health issues for women. Some of the efforts will focus on educating targeted populations on the importance of prenatal care (population based services) and using lay home visitors and outreach activities to increase prenatal care (enabling services). Several National

Performance Measures will be used to monitor progress in this priority area

NPM # 11, 15, 17, 18, OM # 1 -- 5, SOM # 1, HSI # 1a, 1b, 2a, 2b, 7a, 7b, SPM # 7, 8, 9, HSCI # 4

Priority # 10: Apply socio-ecologic models to promote healthy weight by encouraging appropriate nutrition and safe physical activity efforts.

Respondents to the on-line survey conducted as a part of the Title V Needs Assessment identified obesity/overweight as the top health issue for both children and women. Over the past decade, overweight/obesity has significantly increased in children living within the Commonwealth of Virginia. According to the National Survey of Children's Health in 2003, almost one-fourth (24 percent) of Virginia's children are overweight and 15 percent are at risk for being overweight. Lack of regular physical activity, accessibility to calorie dense foods, larger portion sizes, family lifestyles and lack of interest in health and media messages contribute to the childhood overweight dilemma. In addition, many children live in areas that are not conducive to safe physical activity. This approach to the overweight issue includes population-based services such as public awareness and education and coordinating school and community based physical activity programs as well as an infrastructure level approach to monitor obesity data and policy development.

SPM # 2, NPM # 14

/2009/ The state priorities for the 2009 Title V Block Grant Application remain the same as those identified by the 2005 Needs Assessment. //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100
Numerator	111	99	113	143	
Denominator	111	99	113	143	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
2007 data not yet available.
Entry is an estimate based on performance in previous years.

Notes - 2006

2006 data from Virginia Newborn Screening Program.
Numerator = number receiving appropriate follow-up (linked to appropriate specialist)
Denominator = number of confirmed cases

Evidence = info from PCP or specialist, oral or written.

Notes - 2005
Appropriate follow-up = linked to appropriate specialist.
Evidence = info from PCP or specialist, oral or written.

a. Last Year's Accomplishments
During FY 07, the Virginia Newborn Screening Services (VNSS) Program continued to screen all newborns born in the state for the twenty-eight disorders recommended by the American College of Medical Genetics. VNSS followed up on over 19,500 unsatisfactory and abnormal results and assured that confirmed cases were appropriately referred for treatment (see Form 6 for data).

Disease-specific parent fact sheets were translated into Spanish and posted on the VDH website. VNSS, in partnership with Virginia's newborn screening laboratory staff, continued to offer training related to newborn screening and the expanded panel disorders.

The Virginia Genetics Program (VGP) continued to support the metabolic treatment centers at Eastern Virginia Medical School and at the Departments of Medical Genetics of University of Virginia and Virginia Commonwealth University. Under contractual agreements, these centers provide: (1) consultation for providers to facilitate early diagnosis and treatment of infants with abnormal screening results; (2) laboratory services to monitor blood levels and make recommendations for modification of diet and metabolic formula; (3) patient and family education; (4) coordination of genetic testing for the family to assist in making informed decisions; and (5) provision of data and long-term case management information to the VGP.

The Virginia Genetics Program Manager continued to serve on the New York Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC) Advisory Committee and two of its associated work groups. The Director of the Division of Child and Adolescent Health (DCAH) also served on one NYMAC work group. This collaborative presents multiple opportunities for the VGP to be involved in identifying regional barriers regarding standardization of newborn screening testing and treatment and the identification of possible strategies for solutions.

"Regulations Governing Newborn Screening Services" (12 VAC 5-71) became permanent after completing the final regulatory stage review in FY 07.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain screening of twenty-eight inborn errors of body chemistry--metabolic, endocrine, and hematologic.			X	
2. Monitor all abnormal newborn screening results and conduct follow up per protocol including aggressive follow-up on all critical results.			X	
3. Provide metabolic formulas and modified low protein food products to patients diagnosed through VNSS who are <300% of the federal poverty level.		X		
4. Maintain the Virginia Infant Screening and Infant Tracking System (VISITS) birth defects database and ensure that all newborn screening diagnosed cases are included in VISITS.				X

5. Maintain contracts with medical specialists statewide to provide metabolic treatment and consultation.	X			
6. Refer all newborn screening diagnosed cases to Care Connection for Children, the CSHCN program for care coordination.		X		
7. Continue newborn screening related educational activities to healthcare providers and consumers.				X
8. Distribute the newborn screening Parent Brochure to obstetric offices and to hospital based prenatal classes.		X		
9. Review and make recommendations regarding proposed legislation or policies addressing newborn screening issues.				X
10.				

b. Current Activities

Data indicate that VNSS continues to fulfill the mission of identifying newborns with heritable disorders and assuring follow-up. VNSS continues the following activiites: (1) screen all infants for 28 inborn errors of body chemistry; (2) track and follow up all abnormal results; and (3) maintain contracts for three metabolic treatment centers. VNSS refers diagnosed cases to the CSHCN program, Care Connection for Children (CCC). CCC care coordinators assist families in obtaining medically necessary formulas as part of overall services.

Educational materials are distributed to health care practitioners and hospitals across the state via several methods. All educational materials for parents and providers are posted on the VDH website. A new poster was developed this year emphasizing actions practitioners and parents can take to help ensure that newborn screening works for all babies. The poster entitled, "Sometimes, looks can be deceiving…" , is being distributed first to hospitals for display in prenatal and postpartum areas. Later distribution is planned for obstetric, pediatric, and family practice offices.

VNSS received the March of Dimes (MOD) Foundation award for National Leadership in Newborn Screening for being one of the first five states to expand the newborn screening panel to the MOD's recommended 28 disorders. This award was presented to the VDH Commissioner of Health in February 2008.

c. Plan for the Coming Year

In FY 09, VNSS will continue the following: (1) ensure screening of all infants for this panel of inborn errors of body chemistry; (2) track and follow up on all abnormal results and assure that confirmed cases are referred into treatment in a timely manner; and (3) provide necessary education and technical assistance to providers. Newborn screening staff will refer newly diagnosed children to the CCC network for care coordination. An automatic electronic referral system between newborn screening and CCC will be developed by the VDH Office of Information Management.

Educational materials for parents and providers will continue to be disseminated through the web and other mechanisms. Additional educational resources will be developed and disseminated to further newborn screening healthcare provider's knowledge and skills related to the panel of disorders and programmatic activities specific to newborn screening. In addition, the need for new strategies and resources to ensure timely and comprehensive follow up activities will continue to be explored and implemented as appropriate and feasible.

Work continues on the VNSS report, "The Years in Review: From Guthrie to Tandem Mass". This report documents the history of and highlights VNSS program activities from 1966 thru 2006. Plans are in place to publish and distribute the document, which is in its final editing stage, by September 2008.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	60	60	60	60	60
Annual Indicator	58.3	58.3	58.3	58.3	59.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	65	65	65	65	65

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
In FY 07, each clinic in the Child Development Clinic network (CDC) surveyed parents to determine their level of satisfaction with care received. Response rates for the ten CDCs ranged from 8 to 92 percent with a network average of 44%. Findings show an overall satisfaction rate of 94%, with a range from 69% to 100%. These percentages have been similar over the years.

The CCC network revised the multi-page standardized Family Satisfaction Survey used in 2006 to be a one-page document (front/back) and plans to repeat the statewide survey every 12 to 18 months. The Virginia Bleeding Disorders Program (VBDP) conducted less formal surveys with very positive comments from the families.

Family representatives continued to serve on the Virginia Early Hearing Detection and Intervention Program Advisory Board, the Hemophilia (Bleeding Disorders) Advisory Board, and the Virginia Genetics Advisory Committee.

CSHCN staff continued to partner with many parent organizations including Family Voices, Parent to Parent, and the federally funded Virginia Integrated Network of Family Organizations

Center (Va-INFO). This coalition of family organizations and local and state partners collaborates and educates on behalf of children and young adults with special needs and their families, and assists them to obtain timely access to information, resources, supports, and services. In September 2006, all CCC care coordinators received training on fostering self-advocacy and family involvement. The CCCs have enhanced their family-to-family support with five centers now employing parents of CSHCN as parent coordinators. Three CCC centers maintained family resource libraries. The Executive Director of Parent to Parent of Virginia was selected to serve in the new capacity of parent delegate to AMCHP.

VBDP continued to host routine meetings of consumer advisory boards for three of the four Hemophilia Treatment Centers. One CDC has an advisory group with participation of parents, a local pediatrician, school personnel, mental health workers, and social services workers. Each CCC continued to have advisory committees to increase family and community involvement in addressing issues relevant to the needs of the special needs population.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include family members and youth with special needs as members of committees and advisory boards of the CSHCN program.				X
2. Provide family-to-family support as a basic service of Care Connection for Children (CCC) centers.			X	
3. Work with Va-INFO and other family organizations to enhance the ability of families to partner in decision-making.				X
4. Administer parent satisfaction surveys at CCC centers, Child Development Clinics (CDC), and the Virginia Bleeding Disorders Program (VBDP).				X
5. Monitor activities and outcomes; adjust CSHCN state plan for meeting HP 2010 goals as needed.				X
6. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
7.				
8.				
9.				
10.				

b. Current Activities

Almost 60% of Virginia families who completed the National Survey of CSHCN in 2005/2006 indicated that they felt they are partners in decision-making at all levels and satisfied with services their children received. This is very close to the state's 2007 objective of 60%, an increase from the 58.3% result in the 2001 survey, and is higher than the 2005/2006 national average of 57.4%.

CDC's informal satisfaction surveys indicate that a majority of families are satisfied with services. A VBDP formal family and client satisfaction survey found 84% very or somewhat satisfied with their care. Issues identified include the need for adequate insurance coverage and assistance with transition. With all surveys, suggestions for improvement are analyzed for implementation.

In March 2008, a Family Satisfaction Survey (English and Spanish versions) was mailed to clients receiving CCC services statewide, with an overall response rate of 45%. Similar to the 2006 survey, the statewide overall satisfaction rate was high at 92% (ranging 88 to 95%). No statistical differences were found in satisfaction rate between recipients of the English and Spanish

versions.

The sixth CCC will employ a parent coordinator. In April 2008, the director of Parent to Parent of Virginia facilitated the first meeting of the CCC parent coordinators. Ongoing meetings are planned to promote networking, sharing, and training. The group will be involved in strategic planning for increasing family involvemen

c. Plan for the Coming Year
Families will continue to serve on advisory boards of the CSHCN Program. All six CCCs will have parents of CSHCN as members of CCC teams and continue to enhance their family-to-family support services. CDCs, CCC centers, and VBDP will survey families to determine their satisfaction with the services and make necessary changes to best meet identified needs. VBDP will continue to host routine meetings of consumer advisory boards of the Hemophilia Treatment Centers.

CSHCN staff will work with community partners to foster the establishment of a steering committee for the development of an alliance in Virginia committed to identification and promotion of strategies to achieve the national CSHCN outcomes. VDH will continue to partner with Va-INFO and other family organizations.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	60	60	60	60	60
Annual Indicator	54.5	54.5	54.5	54.5	43.9
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	60	60	60	60	60

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
In FY 07, 98 percent of the clients in the Child Development Clinic (CDC) network and 100 percent of both the Care Connection for Children (CCC) network and the Virginia Bleeding Disorder Program (VDBP) had a primary care provider.

All children seen for CDC and CCC services were screened to determine if they had a primary care provider. Families without a primary care provider received encouragement to establish a medical home and were informed of choices to obtain one. CDCs have a performance goal to improve communication with the medical home by sending the clinic's final report to the medical home within fourteen days of completion of the CDC team evaluation. Results on this performance target ranged from 48 to 100 percent when permission was given to release the report, with a CDC network average of 82%. This marks significant improvement from the 50% network average in 2006.

All CCCs have developed collaborations with local public and private pediatric mental health service providers. Access to mental health services in Virginia is limited for multiple reasons including shortages of pediatric mental health resources, low insurance reimbursement, and families having to pay prior to services being rendered. One CCC co-sponsored a conference in their community on "Expanding Your Comfort Zone…Include Psychiatry in Your Pediatric Practice".

Staff participated in the "Virginia Oral Health Summit: Strong Roots for a Healthy Smile". It brought together parents of CSHCN, dentists and oral health providers, health professionals, state agency leaders, and policy makers to talk about improving access to oral health care for children with disabilities. A strategic plan was an outcome for this event.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with other community agencies to expand the availability of medical homes for CSHCN.				X
2. CCCs, CDCs, and the Bleeding Disorders Program work with families to ensure that children served are referred to a medical home.		X		
3. Partner with state AAP, Medical Home Plus, and other organizations to provide training and technical assistance to primary care practices on the medical home concept.				X
4. Monitor activities and outcomes; adjust CSHCN state plan as needed.				X
5. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Of the families in Virginia who completed the National Survey of CSHCN in 2005/2006, 43.9% indicated that their CSHCN received coordinated, ongoing, comprehensive care within a medical home. This is far from the state's 2007 objective of 60%, a decrease from the 54.5% result in the 2001 survey, and is lower than the 2005/2006 national average of 47.1%. Even though this indicator is not comparable across survey years, improvement is needed. Analysis of specific components of the medical home indicator is underway to better define the areas where

improvement efforts should be directed.

The CSHCN Program continues to implement the Virginia plan to meet HP 2010 outcomes for CSHCN and their families including partnering with the state AAP, Medical Home Plus, and other organizations to seek funding for continued spread of the medical home concept.

Staff continues to participate in the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC) to promote medical homes and a system of care for CSHCN identified through newborn screening. This NYMAC work group is prioritizing projects and has not finalized a plan; however, there will be initiatives targeted to providers and parents, and Virginia staff will take advantage of this collaboration's outputs.

c. Plan for the Coming Year

Assisting families with locating a medical home and providing technical assistance and training for health professionals about the medical home concept will have higher priority for the CSHCN Program. The plan to meet this HP 2010 outcome will be evaluated and mechanisms for improvement will be implemented. Specific activities will be designated and included in work plans for CCCs, CDCs, and VBDP.

CCC centers, CDCs, and VBDP will continue to monitor the status and refer 100 percent of their clients without a medical home to resources. The Oral Health Strategic Plan will be implemented.

Staff is following the current work of the National Academy for State Health Policy (NASHP) on medical home, and will partner with the Department of Medical Assistance Services to explore possible ways that Medicaid/SCHIP policy may be used to promote medical homes.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	67	68	70	70	70
Annual Indicator	65.6	65.6	65.6	65.6	63.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	75	75	75	75	75

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The Care Connection for Children centers (CCC), Child Development Clinics (CDCs), and Virginia Bleeding Disorder Program (VBDP) prepared their annual plans based on the HP 2010 outcomes for CSHCN. All three are contractually required to refer all eligible children without insurance to either Medicaid or FAMIS (SCHIP) and to refer potentially eligible SSI recipients to SSI. They are also required to follow-up with families to determine the outcome of the applications.

A major component of the CCC program is the provision of insurance case management to assist families to obtain, understand, and use health insurance. CCC staff participated in community groups to promote enrollment of uninsured children in public programs.

In FY 07, 98% of CDC network, 91.1% of CCC network, and 90.4% of VBDP clients had health insurance coverage. In all three programs, 13.7 percent of clients under age 16 years also were receiving SSI.

In FY 07, 453 clients (CCC: 437 and VBDP: 16) received financial assistance from the CSHCN Pool of Funds (POF). This Pool provides money to assist uninsured and underinsured clients. Covered services include durable medical equipment, medications, diagnostic testing, therapies, hospitalizations, and dental orthodontic and prosthodontic appliances (for those with maxillofacial conditions). The POF was evaluated to identify areas of underinsurance and services not covered. Medications and durable medical equipment continue to be the most requested POF services.

The CSHCN Program continued work with DMAS to remove obstacles causing underinsurance of CSHCN on Medicaid and FAMIS. DMAS provided updated manuals and training for CCC centers, VBDP, and CDCs.

The "Care Coordination Notebook: Financing and Managing your Child's Health Care" was translated into Spanish and distributed. It serves as a training tool for the parent trainers and a "working" guidebook to maintain children's health care records. The final report on the MCHIP CSHCN Health Insurance and Financing Grant was completed and products from the grant were shared nationally.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Refer 100% of eligible children in the CCCs, CDCs, and the Bleeding Disorders Program to Medicaid, FAMIS, and SSI.		X		
2. Provide health insurance case management as a basic service of the CCC centers and the Bleeding Disorders Program.		X		
3. Monitor activities and outcomes; adjust the CSHCN state plan				X

as needed.				
4. Work with other agencies to identify issues and remove obstacles that cause underinsurance.				X
5. Provide financial assistance from the CSHCN Pool of Funds for the uninsured and underinsured clients of CCC and VBDP.		X		
6. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
7.				
8.				
9.				
10.				

b. Current Activities

Of the families in Virginia who completed the National Survey of CSHCN in 2005/2006, 63.7% indicated that they have adequate private and/or public insurance to pay for services their children need. This is lower than the state's 2007 objective of 70%, as well as a decrease from the 65.6% result in the 2001 survey; however, it is higher than the 2005/2006 national average of 62%.

CDCs, CCCs, and VBDP continue to refer all potentially eligible children to Medicaid, FAMIS, and SSI programs and follow-up with families to assure that the application is processed. The majority (93.2%) of clients continue to have health insurance coverage. The number with no insurance decreased from 7.6% in FY 04 to 6% in FY 05 and FY 06, and then increased to 6.4 % in FY 07. Many within this group are not eligible for public insurance and cannot afford private insurance.

The Family Satisfaction Survey conducted by VBDP noted that 66% of those with health insurance found costs to usually or always be reasonable. All (100%) reported that they were able to see the health care provider of their choice.

Clients continue to receive financial assistance from the CSHCN POF with the number served increasing from 324 in FY 06 to 435 in FY 07. POF guidelines have been modified in an effort to address areas of underinsurance. Staff continue to work with DMAS to identify issues and remove obstacles that cause underinsurance of CSHCN receiving Medicaid and FAMIS.

c. Plan for the Coming Year

CDCs, CCC centers, and VBDP will continue to refer all potentially eligible children to Medicaid, FAMIS, and SSI programs and follow-up with families to assure that their applications are processed. They will continue to provide annual plans based on the HP 2010 outcomes for CSHCN. Future Pool of Funds evaluation activities include assessing predictors regarding lifetime costs and cost-savings analyses.

Clients will continue to receive financial assistance from the CSHCN Pool of Funds, and the funds will continue to be evaluated to identify areas of underinsurance and services/fees not covered by these funds. Work with DMAS will continue to identify issues and remove obstacles that cause underinsurance of CSHCN receiving Medicaid and FAMIS. Updated manuals and training by DMAS will be provided for CCC centers, VBDP, and CDCs.

Staff will provide data and information on insurance status and gaps in coverage to child health advocates and coalitions working to increase insurance coverage for children in Virginia.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	82	82	83	85	85
Annual Indicator	80.1	80.1	80.1	80.1	89.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	90	90	90

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The CSHCN Program maintained its network of six Centers of Excellence called Care Connection for Children (CCC). The centers provided information and referral to resources, care coordination, family-to-family support, assistance to families with the transition from child to adult oriented health care systems, and training and consultation with community providers on CSHCN issues.

The network of ten Child Development Clinics (CDC)s provided interdisciplinary evaluations of children suspected of having developmental disorders or emotional, behavioral, or psychosomatic problems. CDCs provided trainings/technical assistance to providers in the community; served as training sites for social work, nursing, and psychology students; provided services to foster care children; and held field clinics to strengthen the community-based service system.

The Virginia Bleeding Disorders Program (VBDP) supported a statewide network of comprehensive care centers for clients of all ages with inherited bleeding disorders and their families.

In FY 07, the CCC network provided care coordination and pool of funds services to 3,739 clients. An additional 1,938 children benefited from CCCs information and referral services. The VBDP served 251 clients (138 persons ages 0-21 and 113 persons 21 years and older). The CDC

network served a total of 2,455 clients. Multidisciplinary diagnostic evaluations, team medical conferences, and care coordination were provided for 1,499 clients. An additional 177 clients were assessed for eligibility for Virginia's Medicaid Developmental Disability Waiver. Another 799 clients received other services, including developmental screens, medical treatment, and/or follow-up counseling services.

CCC staff was actively involved in providing care coordination services for newly diagnosed cases identified in the expanded newborn screening (dried bloodspot) panel. A new state law effective March 1, 2007 requires referral to CCC. In addition, the staff assisted in the transition of 56 children who were receiving metabolic formula from the health department's formula distribution program to a new purchase model (families without insurance coverage for formulas can purchase it at discount through the Health Department). Care coordinators actively assisted families with applicable insurance preauthorization and appeal processes for coverage of metabolic formula; they also assisted those with insurance coverage in finding local vendors of metabolic formula. Eligible clients were assisted in obtaining public insurance, and staff worked with DMAS to assure coverage for metabolic food and formulas under EPSDT policies. The CSHCN Pool of Funds purchased metabolic formulas for eligible children.

During FY 07, CCC staff began providing care coordination services for newly diagnosed cases identified through newborn hearing screening. Staff maintain close working relationships with local early intervention programs. One of the CCC centers is housed with the local early intervention program, which enhances referrals and collaboration in the delivery of services. Another useful resource is the Hearing Aid Loan Bank funded by Virginia Early Hearing and Intervention Program.

During FY 07, fourteen CCC staff maintained their national case management certification (37% of the staff). The number is steadily increasing each year toward the goal of 60%.

Regulations for the CSHCN Program ("State Plan for the Children with Special Health Care Needs Program" 12 VAC 5-191) became permanently effective after completing the final regulatory review stage in FY 07.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide leadership in planning, developing, and implementing efforts to improve services to CSHCN.				X
2. Provide care coordination for CSHCN from birth through twenty years of age in CCC and persons of all ages in VBDP.		X		
3. Provide a system of services for people with bleeding disorders through the Bleeding Disorders Program.	X			
4. Provide diagnostic and evaluation services for children from birth through twenty years of age through the Child Development Clinics.	X			
5. Partner with others to coordinate care for children with behavioral programs through the Child Development Clinic network.		X		
6. Monitor activities and outcomes; adjust the CSHCN state plan as needed.				X
7. Participate in statewide committees and interagency councils for CSHCN issues.				X
8. Provide training and technical assistance.				X
9. Review and make recommendations regarding proposed				X

legislation or policies addressing CSHCN.				
10.				

b. Current Activities

Almost 90% of the families in Virginia who completed the National Survey of CSHCN in 2005/2006 indicated that services for their children are organized in ways that allow ease of use. This percentage is higher than the state's 2007 objective of 85%, marks an increase from the 80.1% result in the 2001 survey, and is higher than the 2005/2006 national average of 89.1%. Even though this indicator is not comparable across survey years, the result is indicative of positive changes that have occurred in the CSHCN service delivery system.

All of the networks in the CSHCN Program continue to evaluate their services and make changes as needed. Collaboration with families and community agencies continues to strengthen delivery of services for CSHCN. Currently, high priority is given to assisting CSHCN and their families to deal with emergencies. Examples include assisting families to develop an emergency care plan and assemble a Disaster Supplies Kit. Staff are also involved in planning for emergency shelters for special needs populations.

Staff are working with partner agencies to continue to strengthen the system of care for CSHCN. Staff work with the Commission on Youth in updating the compendium of evidence-based and best practice treatments for children and adolescents with behavioral health disorders. The Division Director represents the agency on Part C (Early Intervention) advisory councils and stakeholder groups that are overseeing the system transformation.

c. Plan for the Coming Year

CDCs will continue to strengthen relationships with other community providers to coordinate services, reduce duplication of services, determine unmet needs, and assure that the children with the greatest need are served. Clinics continue to provide annual plans based on the HP 2010 outcomes for CSHCN.

The CCC centers will continue in their mission to develop family-centered, culturally competent, and community-based systems of referral and care and to simplify access to these systems for families. Changes in the CCC database are planned to allow electronic referrals from newborn screening programs to CCC. The system will also inform the screening programs of the outcomes of the referrals. Mechanisms will be explored to electronically capture the number of persons served by CCC's family to family services.

VBDP will continue to implement strategies to improve services resulting from the study of adult hemophiliacs. Seminars planned include home infusion and coagulation update. Strategies to reach adult hemophiliacs using telemedicine are being explored. Several family outreach activities and health care professional trainings are planned. Collaboration will continue with the Virginia Chapter of the National Hemophilia Foundation to facilitate training and networking events for clients.

DCAH leadership and staff will continue to support implementation of models for service delivery that foster a coordinated system of care across and between programs.

A critical factor in organizing systems of care is early identification of CSHCN through routine, periodic screening and referral to follow up services. In FY 08, VDH joined with DMAS, AAP, and the Part C system in the Assuring Better Child Health and Development (ABCD) Project, supported by the National Academy for State Health Policy. ABCD promotes routine surveillance for risk factors and the use of standardized tools by primary care providers as part of well-child visits to conduct developmental screening. Abnormal findings trigger intervention and repeat screening or follow up for further evaluation. Two pilot sites (one private pediatric practice and one health district) are involved in the ABCD project to document the impact of routine screening.

In addition, DCAH purchased the Ages and Stages Questionnaires for all local health districts and produced an in-service DVD on use of this system. ABCD is also recommending policy changes to promote screening (a list of preferred screening tools for EPSDT reimbursement; perinatal depression screening by pediatric providers). An "universal" referral form has been developed and is being piloted by Part C to better communicate referrals from and assure results back to primary care providers. DCAH will continue to build ABCD project efforts in FY 09 aimed at simplifying and improving the organization of services to CSHCN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	5.8	5.8	6	7	8
Annual Indicator	5.8	5.8	5.8	5.8	37.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	45	45	45	45	45

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
Virginia's plan to meet HP 2010 outcomes for CSHCN includes numerous activities to facilitate the development of a transition system for CSHCN: assure that youth with SHCN participate as decision-makers and as partners; have access to health insurance coverage; and have a medical home that is responsive to their needs. Specific activities have been included in the contractual arrangements with local managers of the clinics and centers in all Care Connection for Children (CCC), Child Development Clinics (CDCs), and Virginia Bleeding Disorder Program (VBDP) networks. These include identification of all open cases of children age 14 years and above to

prioritize the group targeted to receive transition services for health care, education, social, and employment needs. CCC and the VBDP are identifying "adolescent friendly" specialists to assist with transitions. Having educational consultants located in CCCs, CDCs, and hemophilia clinics has greatly enhanced communications with the local schools regarding youth clients' transition services.

CDCs focus on serving younger children to identify developmental, behavioral, and emotional problems as early as possible. Given the younger age group most commonly served and shorter duration of service time for clients, the CDC role in providing transition services is limited. Nevertheless, there were 63 CDC clients who were referred to their local school systems for transition services. In addition, CDCs worked with their local schools to identify the unmet needs of middle school students in special education to aid in their transition to high school. When appropriate, adolescents were invited to participate in the interpretive interview of their evaluation findings and recommendations either with their parents or by having their own separate individual interpretive interview. Recommendations related to transition to adult life were included.

The CCC care coordinators continued to update their Transition Tool Kit. The kit includes specific worksheets organized by aspects of transition to be used during encounters with the client and family. These worksheets help to identify the client's strengths and challenges during the transition process. They also serve as a measure of progress toward transition over time. The minimum goal is to provide at least five transition encounters between the client, family, and care coordinator. Divided into five age groups between ages 14 and 21 years, the worksheets provide a mechanism to prompt and track progress towards that goal. The kit also includes a sample emergency information form for families to complete and provide to caregivers, emergency rooms, day care providers, and other relevant persons who may be part of the youths' care network.

CCC staff partnered with the Department of Education and the Department of Rehabilitative Services in the planning and implementation of the state's 2007 Transition Forum.

A subcommittee of the Hemophilia Advisory Board explored barriers to the transition of patients with inherited bleeding disorders and made recommendations for strategies to be considered by the VBDP to ameliorate these barriers. The recommendations approved by the Board included identifying core competencies for adequate patient transition to be monitored via pre/post test, developing a portable, accessible medical record to be given to the patient and family, and ensuring the availability of affordable, comprehensive, continuous health insurance.

In September 2007, CCC care coordinators received training entitled "Special Education, Spanning the Continuum from Early Intervention through Transition to Independent Living".

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide transition of services from pediatric to adult health care services in the CCCs, CDCs, and the Bleeding Disorders Program.		X		
2. Monitor activities and outcomes; adjust the CSHCN state plan as needed.				X
3. Review and make recommendations regarding proposed legislation or policies addressing CSHCN.				X
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Of the families in Virginia who completed the National Survey of CSHCN in 2005/2006, 37.8% indicated that their older children have received the services necessary to make appropriate transitions to adult health care, work, and independence. This finding is higher than the state's 2007 objective of 8% and represents an increase from the 0.4% result in the 2001 survey, but is lower than the 2005/2006 national average of 41.2%. Even though this indicator is not comparable across survey years, the result is indicative of the enhancements in transition services in the health, education, mental health, and rehabilitation agencies in Virginia.

CDCs, CCCs, and VBDP continue to assist youth in the transition to adult care. CCC staff partnered with the Departments of Education and Rehabilitative Services to implement the state's 2008 Transition Forum.

Staff participate with the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC). Two other regional consortia and the NYMAC are piloting transition initiatives. Virginia will take advantage of any opportunities that may come from this effort.

VBDP hosted a transition summit for treatment centers' social workers. Discussion included ways to implement transition tools in a clinic setting and have multidisciplinary, collaborative planning. A strategic plan for future activities was developed. One product is the portable, accessible medical summary given to the patient and family.

c. Plan for the Coming Year

CDCs, CCC centers, and VBDP will continue to assist older children in the transition to adult care. Virginia's plan to meet the HP 2010 transition outcome for CSHCN will be implemented. The Transition Tool Kit will continue to be updated and shared with community partners. The VBDP will be adding information and links to the VBDP web site to educate youth about insurance options as they transition to adulthood.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	79	82	85	85	87
Annual Indicator	84	81	85.8	81.5	86.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**

Annual Performance Objective	87.5	87.5	88	88	88

Notes - 2007
2007 data not yet available. Entry is an estimate based on trend.

Notes - 2006
National Immunization Program Data Calendar Year 2006 from CDC website.

Notes - 2005
National Immunization Program Data Calendar Year 2005 from CDC website.

a. Last Year's Accomplishments
Data tracked within VDH indicate that coverage rates are slowly increasing over time. In 2006, the immunization rate for 4:3:1:3:3 went down to 81.6%. This appears to be related to drops in Hib and HepB rates.

In FY 07, Title V supported activities related to increasing immunization rates focused on the provision of child care health consulting activities, including assessment. The Title V Early Childhood Projects director, along with the contracted state child care health consultant, supervised Healthy Child Care Virginia (HCCV) training and technical support activities for public health nurses and other professionals serving as child care health consultants. Key consulting activities are to provide CASA immunization audits and help child care centers institute system changes to support all attendees reaching and maintaining up-to-date immunizations. The director provided consultation to the Department of Social Services to work with child care providers in developing their knowledge and ability to assure complete immunizations among child care attendees. A part-time contracted coordinator provided ongoing consultation and technical assistance to the field. Nine health districts used Title V funds to support activities related to increasing immunization rates through assessment, early childhood asthma management, and child care health consultant activities.

Title V supported several state and local efforts to provide parents and caregivers with information about immunizations. The Governor's New Parent Kit, initiated in 2004, was distributed throughout the state. The kit contains a broad array of information related to infant and child care. In FY 07, 60,512 English and 11,382 Spanish kits were distributed. VDH Resource Mothers, along with partners CHIP of Virginia and Healthy Families, led distribution efforts. VDH prenatal clinics were encouraged to routinely distribute the kit to their clients. The kit contains the Bright Futures Health Record and a customized Baby's First Year calendar highlighting immunizations needed for each month including stickers to put on dates received and the toll-free VDH Division of Immunization information line.

Title V funds support case management activities that help increase immunizations. Resource Mothers, a lay-person support program available in 87 communities, continued to assist teen parents in getting their infants properly immunized. Roanoke health district used some of their Title V allocation to support their CHIP case management program for low-income children ages 0-5. In FY 07, 95% of Virginia CHIP enrollees were up-to-date at age two for the basic series (4:3:1:3).

Other statewide activities to increase immunization rates were administered and funded through other sources. The Virginia Immunization Information System (VIIS), which is the state's immunization registry, continues to be developed through the Division of Immunization, Office of Epidemiology. Other activities included provision of immunizations through all local health departments; development and implementation of local immunization action plans; collaboration with public and private sector partners such as WIC and Medicaid HMOs; and surveillance, CASA assessment and evaluation activities led by the VDH Division of Immunizations, Office of Epidemiology.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide funding to local health districts to deliver child care health consultation services to help increase immunization rates.				X
2. Promote Bright Futures Guidelines to increase utilization of prevention health care.				X
3. Support home visiting programs such as CHIP and Resource Mothers.		X		
4. Participate in Project Immunize Virginia Coalition.				X
5. Collaborate with stakeholders to publish information regarding immunization requirements including distribution of New Parent Kits.		X		
6. Review and make recommendations regarding proposed legislation or policies addressing access to health care, particularly immunizations.				X
7. Provide support to the Virginia Immunization Registry as needed.				X
8.				
9.				
10.				

b. Current Activities

Title V supported activities continue a major emphasis on working with child care providers to improve immunization rates and other health indicators. The Early Childhood Projects director and contracted coordinator conducted one training in FY 08, increasing the number of child care health consultants to over 300 statewide. With Title V funding, ten health districts are conducting child care health consultant activities to improve immunization status in all tiers of child care. Districts review CASA results to determine how they can work with local child care providers to improve rates within their areas. Education, training, and outreach activities for child care and Head Start staff to monitor immunization records are being conducted to assure that 80 percent of two-year-olds are adequately immunized.

Title V continues to partner with the Virginia Department of Social Services (DSS) in reaching child care providers. A quarterly Healthy Child Care newsletter was converted from paper to an electronic format and reaches over 10,000 child care providers throughout the state. Topics focus on timely issues including the importance of immunizations and keeping children's medical records up-to-date, health insurance, disease prevention, mental-health and social-emotional competence, and working with children with special health care needs.

The New Parent Kit continues to be distributed and is well-received as a comprehensive package of critical information for parents.

An attachment is included in this section.

c. Plan for the Coming Year

Since the statewide launch in FY 05, over 160,000 Governor's New Parent Kits have been provided to community partners for distribution. The New Parent Kit, geared for parents or other primary caregivers, contains several items providing immunization information and resources. Resource Mothers continues to distribute these kits and provide support for teen parents to ensure their infants are adequately immunized.

The contracted child care health consultant will continue providing technical assistance to field staff through the end of the State Early Childhood Comprehensive Systems grant funding. To build sustainability, child care health consulting has been incorporated as a working committee under the VDH Nursing Council. Consultation and partnering with Project Immunize Virginia, the VDH Division of Immunization, Head Start Collaborative, and the DSS Divisions of Child Care Programs and Licensing will continue to assist with infrastructure building and quality enhancement activities. The Child Care Health and Safety Newsletter will continue to be published quarterly.

In FY 09, nine local health districts -- Central Shenandoah, Central Virginia, Chesterfield, Hampton, Lord Fairfax, Norfolk, Peninsula, Western Tidewater, Piedmont, and Rappahannock -- plan to use some of their Title V allocation to support child care health and safety, child care provider medication administration training, and asthma case management.

VDH will be contracting to develop a new Bright Futures web site consistent with the Third Edition of Bright Futures released late in 2007. This site will be searchable, interactive, and focus on the anticipatory guidance themes and periodicity visit schedule. It will replace the current site, which will not be supported after June 30, 2008; the new site is targeted to go live in early 2009.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	19	19	19	17	16
Annual Indicator	17.4	17.5	16.3	16.9	16.6
Numerator	2570	2633	2521	2617	2566
Denominator	147701	150159	154419	154735	154735
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	15.8	15.6	15.4	15.2	15.2

Notes - 2007
2007 provisional data used for number of births to teens. Denominator entry is an estimate based on previous year.

Notes - 2006
Number of teen births from Vital Records 2006 data. Denominator from NCHS 2006 population estimates.

Notes - 2005
Number of teen births from Vital Records 2005 data. Denominator from NCHS 2005 population estimates.

a. Last Year's Accomplishments

The Teenage Pregnancy Prevention Initiative (TPPI), funded solely through Department of Social Services TANF funding, continued in seven health districts as mandated in state budget language since 1993. Teenage pregnancy prevention programs were staffed and monitored. Each program implemented curriculum identified as a best practice or effective program. Quarterly meetings were held for information dissemination, training, and networking. Staff worked in conjunction with VCU-SERL on the TPPI evaluation. A Master Evaluation Protocol (MEP) was used for collecting outcome data by each program. Since 1994, six of the seven districts have experienced declines in teenage pregnancy rates (ages 10-19). One health district has an artifact with induced termination data affecting its rate.

Under a state general fund allocation, 17 Better Beginnings Coalitions (BBCs) were funded and monitored. These coalitions worked to increase awareness and implement community approaches geared toward prevention of teenage pregnancy through youth development, media, and other methodologies. The fifth annual evaluation conference was held to explore current trends in teenage pregnancy prevention programming and research with an emphasis on local level teenage pregnancy prevention activity and coalition building.

The CHATS (Collaborative on HIV/STD, Abstinence, Teenage Pregnancy, and Sexual and Reproductive Health) group met throughout the year and an adolescent sexuality and reproductive health information packet was developed for youth released from juvenile detention facilities. A bi-lingual fact sheet was also developed for broad distribution to youth through the state. This fact sheet contains relevant adolescent sexuality and reproductive health facts and key contact information for services. This group continued its collaborative efforts to integrate teen pregnancy, abstinence, STD and HIV prevention efforts where possible. It also continued to offer "Can We Talk" train-the-trainer sessions.

The Virginia Resource Mothers Program, started in 1986, continued providing lay home visiting services to a total of 2,119 teens in 88 of 135 Virginia localities. Only 5.1% of Resource Mothers participants experienced a repeat pregnancy within the first year after birth versus an estimated 20% for the entire state.

The Virginia Abstinence Education Initiative was discontinued effective September 30, 2007. Funding from the U.S. Administration on Children and Families provided for social marketing campaigns, resource distribution, training, and evaluation of abstinence-based education programs for school-based youth. Program implementation and evaluation activities were closed and activities shifted to the agency close out of the grant according to federal procedures. Over 50,000 "Talk 2 Me" toolkits were provided to parents to assist them in discussing sexuality and other relationships with their children.

Family Planning services were provided in local health departments through Title X funding.

Hispanic outreach efforts included three radio public service announcements and a Web page www.paramihija.com.

Information and promotion of the National Day to Prevent Teen Pregnancy on May 3, 2007 was provided to all field programs and health districts along with district fact pages on teen pregnancy. A training day for providers was held May 8, 2007.

A brochure "Gracias Papa" was developed by the Division of Injury & Violence Prevention in response to professionals requesting materials for Hispanic teens. The brochure has important messages about avoiding sexual coercion by older adults. Hispanic outreach efforts continue and include PSAs and a Web page www.paramihija.com.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate and oversee administration of teenage pregnancy prevention programming in seven health districts: Alexandria, Crater, Eastern Shore, Norfolk, Portsmouth, Richmond City and Roanoke City.				X
2. Fund Better Beginnings Coalitions (BBC) in 17 communities.		X		
3. Evaluate teenage pregnancy prevention programs.				X
4. Support statewide train-the-trainer workshops to help parents talk with their children about sensitive topics including sexuality (e.g., "Can We Talk" curriculum and "Talk 2 Me Toolkit").				X
5. Continue effort to integrate HIV, STD, and teen pregnancy prevention messages.				X
6. Develop the statewide adolescent sexual health plan.				X
7. Develop the skills and capacity of youth service providers to serve the target population through information networks.				X
8. Review and make recommendations regarding proposed legislation or policies addressing teens and their access to health care and other health related services.				X
9. Participate in CHATS and other collaborative efforts.				X
10.				

b. Current Activities

The General Assembly appropriated level funding, through TANF funds, for the Teenage Pregnancy Prevention Initiative for FY08. Quarterly meetings have been held for information dissemination, training, and networking. Staff continue to work in conjunction with VCU-SERL on the TPPI evaluation. Better Beginnings Coalitions (BBCs) have been funded and monitored. An evaluation conference was held on May 30, 2008 to explore current trends in teenage pregnancy prevention programming, and included staff from health districts as well as funded program providers.

In conjunction with the National Campaign to Prevent Teen Pregnancy, Virginia has established a ten-year teen pregnancy reduction goal (Goal 2015) to reduce the pregnancy rate to 47.5 per 1,000 females ages 15 -- 19. We have promoted Goal 2015 and offered technical assistance to localities in an effort to assist them in 1) maintaining focus on the issue and 2) establishing local teen pregnancy reduction goals.

The CHATS group sponsored a very well attended and well received conference in October 2007 entitled "Understanding Youth Development in the Context of the Information Age". The conference was aimed at presenting practical, research-based information on Adolescent Brain Development, Juvenile Sexual Offenders, and Internet Safety to those working directly with Virginia's youth.

Close-out of the Virginia Abstinence Education Initiative (VAEI) was completed in April 2008.

An attachment is included in this section.

c. Plan for the Coming Year

In anticipation of the General Assembly appropriating level funding through TANF for the Teenage Pregnancy Prevention Initiative for FY 09, the seven health districts will continue to maintain their focus on Virginia's Goal 2015, which is to reduce the pregnancy rate to 47.5 per 1,000 females ages 15-19. We will work closely with each locality and provide technical assistance as they implement curriculum identified as a best practice or effective program. Staff will continue to work with VCU-SERL on evaluation of the TPPI endeavors. Site visits will be

conducted for each TPPI program location.

An expected reduction in General Funds has resulted in a moratorium on contracts with the BBC at this time. If funds are maintained, these contracts will be reconsidered for the coming year.

Efforts to secure funding will continue in order to supplement the inventory of existing teen pregnancy prevention materials and to increase awareness of Virginia's Goal 2015.

Central office staff responsible for teenage pregnancy prevention efforts will participate in the Adolescent Health Task Force's System Capacity for Adolescent Health two day meeting currently being planned for late summer 2008. Teenage pregnancy and its connection to gang exposure points to the importance of integrating reproductive health with violence prevention efforts which will be pursued further with appropriate partners. The Governor's Office on Substance Abuse Prevention Collaborative is focusing on the impact of underage drinking and subsequent risk taking by adolescents. Teenage pregnancy is an important outcome of this type of risk taking and will be addressed in this context.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	36	37	39	39	39
Annual Indicator	42.0	43.0	44.0	25.1	29.6
Numerator	856	876	897	50	180
Denominator	2038	2038	2038	199	608
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	40	40	40	40	40

Notes - 2007
Data are derived from dental surveys of school-age children in Virginia. 2007 data are from the 2007 Piedmont Health District Basic Screening Survey of third-grade children. Piedmont is a rural health district and may not be entirely representative of all third graders, but this is the most recent data available. Data presented are unweighted.

Numerator is the unweighted number of children who received a sealant. Denominator is the unweighted number of third grade children examined. Data collection on third graders in targeted counties will continue through 2008.

Notes - 2006
Data are derived from dental surveys of school-age children in Virginia. The data is derived from more than 1,000 third-grade children from targeted counties throughout the state.

Numerator is the unweighted number of children who received a sealant. Denominator is the unweighted number of third grade children examined. Data collection will continue with analyses

and weighting of data in 2007. Weighted numbers are expected to adjust the percent to be in line with the previous years' trends.

Notes - 2005
Data is derived from a statewide needs assessment of school-age children in Virginia. This comprehensive study examined the oral health condition and needs of over 2,000 third-grade children from throughout the state.

a. Last Year's Accomplishments
The Division of Dental Health (DDH) supported local health department dental programs with Title V funds by providing a dentist to coordinate a quality assurance program, assist with recruitment for local health department dental programs, and orient new dental staff. In FY 2007, on-site quality assurance reviews were provided for dental programs in Roanoke City and Alleghany County. VDH dental clinics served 25,592 individuals in 47,766 visits in FY 07. More than 179,000 clinical services, including 17,000 dental sealants, were provided for these patients at a value of more than $14 million dollars. Eighty-five percent of encounters were for school age children. Training was provided for 100 dental staff in 25 health districts regarding pediatric dentistry and other public health dental topics during a two-day meeting. Additionally, staff was trained regarding pediatric dentistry during a teleconference. Norfolk City, Roanoke City, and Thomas Jefferson Health Districts continued to use Title V funds to help support their dental programs.

Title V funds also provided materials for 50,500 children to participate in the school-based fluoride mouthrinse program. The VDH dental hygienist who oversees this program is funded by Title V and provided training to children, teachers, and nurses and conducted on-site reviews of half of the 225 participating schools in 56 counties statewide. An evaluation dental survey of more than 1,000 children was begun involving the counties of Pittsylvania, Halifax, and Charlotte. Of the three, Pittsylvania currently does not participate in the mouthrinse program and children from these counties will be followed and reexamined in three years for comparative decay rates. A survey of 655 children in seven health districts was conducted to pilot the Basic Screening Survey data collection tool. More than 10,000 school age children were educated regarding oral health, which included dental sealant education.

More than five million citizens, including school age children, consume water that has been optimally fluoridated. DDH provides oversight and monitors the systems for compliance in conjunction with the VDH Office of Drinking Water.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Three health districts utilize MCH funding to provide sealants.	X			
2. A quality assurance program provides on site review of all health department dental programs that placed more than 17,000 sealants in FY 07.	X			
3. Maintain a data entry program to record the number of oral health services provided.				X
4. Recruitment and orientation of new dentists.				X
5. Develop and distribute educational materials regarding dental sealants.			X	
6. Train local public health dental staff on pediatric dentistry to provide a competent oral health workforce.		X		
7. Review and make recommendations regarding proposed legislation or policies addressing children's access to dental				X

care.				
8. Provide education regarding dental sealants to more than 10,000 school age children.			X	
9. Collect and analyze data on 3rd grade children regarding disease status and dental sealants.			X	
10. Pilot a school based dental sealant program.	X			

b. Current Activities
Another area of emphasis of the grant is training for providers to increase services to children with special needs.

DDH has piloted a curriculum this year to be used by school nurses and teachers to promote integration of oral health into school curriculums for elementary, middle, and high school students. Targeted areas for expansion of the school rinse program this year include areas in southwest Virginia, specifically Wise and Dickenson Counties. DDH is currently piloting a school dental sealant program based on data collected last year in seven counties. (Staff time is covered by MCH and funding for materials is provided by the Preventive Health and Health Services Block Grant). DDH dental program oversight has continued and is ongoing with site visits, recruitment, and orientation. DDH assisted in the purchase and delivery of three mobile dental vans. One of the vans was used to start a dental program in Richmond City; one other is being used for the TOHS Grant.

An attachment is included in this section.

c. Plan for the Coming Year
DDH hopes to increase the number of low income children receiving dental preventive services through the fluoride varnish program by increasing staff capacity in that area. Activities will be based on the success of various pilots such as the school sealant program. DDH dental program oversight will continue as dentists retire from the VDH systems with site visits, recruitment, orientation, and training. DDH is applying for funding to complete a statewide third grade school survey and hopes to complete other open mouth surveys of targeted groups.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	2.1	2.1	2.1	2.1	1.9
Annual Indicator	2.7	1.9	2.7	1.9	2.1
Numerator	41	29	41	28	
Denominator	1496098	1497931	1508838	1490293	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	1.9	1.9	1.8	1.8	1.8

Notes - 2007
Data for 2007 not yet available. Entry is an estimate based on trend.

Notes - 2006
Data from 2006 Death Certificate File.
Relevant changes in Virginia Law:
July 1, 2002:
--All children under age six must be properly restrained in a child safety seat or booster seat. Violations will result in a $50 fine.
--All children between their 6th and 16th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.
July 1, 2007:
--Child restraint devices are required for children through the age of seven (until 8th birthday). Violations will result in a $50 fine.
--Rear-facing child restraint devices must be placed in the back seat of a vehicle. In the event the vehicle does not have a back seat, the child restraint device may be placed in the front passenger seat only if the vehicle is either not equipped with a passenger side airbag or the passenger side airbag has been deactivated.Violations will result in a $50 fine.
--Children can no longer ride unrestrained in the rear cargo area of vehicles. Violations will result in a $50 fine.
--All children between their 8th and 16th birthday must be properly restrained by a child restraint system or a safety belt. Violations will result in a $50 fine.

Notes - 2005
Data from 2005 Death Certificate File.

a. Last Year's Accomplishments
Title V funded staff in the Division of Injury and Violence Prevention (DIVP) to provide oversight to a statewide child transportation safety program that is funded through a variety of other state and federal sources. DIVP staff coordinated the Child Passenger Safety Week Observance (February 11-15, 2007) by mailing out educational resources to 10,000 licensed daycare centers and family day homes, CHIP, Head Start Centers, pediatricians, local health departments, Safe Kids coalitions, elementary schools, and law enforcement offices. Agencies and organizations were also able to request additional materials to support efforts in their communities. Almost 30,000 additional child passenger safety brochures, videos, posters, activity books, and growth charts were mailed out as a result of these requests. DIVP also provided mini-grants to ten agencies to encourage them to conduct events in their communities during this week. In addition, over two hundred safety seats were inspected at ten community safety seat check events conducted during that week. This project was funded through federal highway safety funds.

DIVP staff coordinated a state funded child restraint distribution and education program which involves restraint dissemination to low income families, training on correct usage, and public awareness. Between the inception of the VDH Low Income Safety Seat Distribution and Education Program in 1996 and December 2007, approximately 105,200 child safety seats have been distributed to qualified children across the Commonwealth. A critical component of the program is the comprehensive education provided to each family receiving a seat by more than 300 trained program staff in more than130 local distribution sites across Virginia. There were several changes to the program in 2007. Program eligibility guidelines were increased to allow the income eligibility to fall in line with the FAMIS and FAMIS Plus child health insurance programs so that more children are eligible for seats. With the amendment to the Virginia child passenger law in 2007 that increased the age of children that are required to be in a safety seat to seven, the maximum age of children eligible for this program was increased from 5 to 7. To be able to appropriately serve this age group, the program now offers belt positioning booster seats and convertible seats.

DIVP staff partnered with various community organizations to develop a network of locations across Virginia that are accessible to the public to have the installation of their child safety seats checked. The Division has partnered with various public health, law enforcement, healthcare, fire, and EMS agencies to develop this network. Trained personnel at these locations check the installation of the seat and identify any manufacturer recalls, as well as correct any installation problems found. Many of these agencies incorporate inspections into their regular duties as a courtesy to their communities. This program provides communities with an important service and provides those agencies involved the opportunity to network and create new partnerships. Currently, there are 108 stations throughout the state. DIVP has also partnered and/or coordinated 47 community based child safety seat check events across Virginia in a dynamic partnership with Virginia SAFE KIDS coalitions, local and state law enforcement, EMS, and health departments. Approximately 646 seats were inspected at these events.

Additionally, DIVP coordinated a Buckle Up Challenge project using Title V resources. To raise awareness about motor vehicle safety and the importance of seatbelt use, high schools were encouraged to participate in the Buckle Up Challenge from April to June 2007. The challenge to any participating school was to increase seatbelt usage among anyone driving on school grounds. Participating schools conducted a student led observational survey to determine the usage rate. Schools then implemented a variety of activities to encourage more students to buckle up and repeated the survey to determine if there was an increase. Schools that demonstrated a 70% or higher usage rate received a certificate.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Coordinate statewide child restraint distribution and education program.				X
2. Disseminate child restraint devices.		X	X	
3. Encourage High School Buckle-up campaigns.		X		
4. Provide public and provider education materials.		X		
5. Review and make recommendations regarding proposed legislation or policies addressing motor vehicle safety issues for children.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DIVP staff are continuing to coordinate a state funded child restraint distribution and education program. The Division is continuing to support over 100 permanent safety seat "fit" stations across the Commonwealth. DIVP staff also continue to support community based child safety seat check events across the state. DIVP staff are working with maternity hospitals throughout the state to encourage the safe transportation of newborns from hospitals through the adoption of policies and the provision of resources and training opportunities for hospital staff. The Division has also begun to coordinate the annual Child Passenger Safety Week observance, which will be held in September 2008.

An attachment is included in this section.

c. Plan for the Coming Year

DIVP staff will continue to disseminate child restraint devices, coordinate state and local child restraint outreach and education activities, and collaborate with state community and highway safety partners to implement a variety of strategies to involve Virginia's parents, youth, and the general public in preventing injuries associated with motor vehicles. Staff will continue to monitor state and federal legislation that impacts child safety.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				40	43
Annual Indicator			39	39	49.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	49	50	51	52	53

Notes - 2007
2007 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2004.

Notes - 2006
2006 Data not available. Entry is an estimate based on CDC's Breastfeeding National Immunization Data for birth cohort 2003.

Notes - 2005
Data from CDC National Immunization Survey, 2005.

a. Last Year's Accomplishments
The Division of WIC & Community Nutrition Services (DWCNS) worked with the University of Virginia (UVA) to develop a web-based training course in lactation management during 2007. The course offers free continuing medical education units to physicians and free continuing education units to other health care professionals such as nurses, dietitians, pharmacists, etc. UVA will continue to host the course through http://www.breastfeedingtraining.org until February 2009. Participation and evaluations will be tracked through the web site.

VDH's Statewide Breastfeeding Advisory Committee convened four meetings in 2007. The committee is composed of high level stakeholders throughout the Commonwealth who hold a vested interest in breastfeeding. Each of these high level stakeholders represents a professional medical organization (AAP, ACOG, academia, ILCA, ACNM, breast pump manufacturers, Virginia Cooperative Extension, Military installations, etc.).

DWCNS used the funding awarded from the United States Department of Agriculture (USDA) to continue to develop the Breastfeeding Peer Counselor Program in Virginia. Materials were developed and all WIC coordinators in the state were trained on the new peer counselor program

using the Best Start Social Marketing's Loving Support Breastfeeding Curriculum.

Currently, the only data source reporting breastfeeding rates that is available to Virginia is the National Immunization Survey from the Centers for Disease Control and Prevention. This data source is historically two to three years behind in reporting. Therefore, Virginia is using breastfeeding data from a 2005 birth cohort.

In 2007, Virginia embarked on a Breastfeeding Media Marketing Campaign, which will continue through September 30, 2008. This campaign included television ads, radio ads, out-of-home marketing efforts, and a Cox/Comcast Cable Video On Demand breastfeeding segment. To date, we have had 3,900 television ads and 4,800 radio ads hit the airwaves, as well as 300 internal bus cards, 14 metro signs, 40 bus rail displays, and three rotary billboards displayed throughout the Commonwealth. The Cox Cable Video On Demand averages 318 views per month while the Comcast Cable Video On Demand averages 738 views per month.

Virginia also developed a web-based training for healthcare professionals on lactation management. This course offers free continuing education units to physicians, nurses, dietitians, pharmacists, and many other healthcare providers. To date, 1,260 healthcare professionals have registered for the course and 1,050 have completed the course. On October 1, 2008, Virginia will launch new modules related to breastfeeding the pre-term and late pre-term infant.

Due to the nature of the programs, Virginia cannot evaluate which program has had the most impact on breastfeeding rates in the Commonwealth.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the Breastfeeding advisory committee.				X
2. Continue the Breastfeeding Peer Counselor Program.		X		
3. Promote Breastfeeding during Breastfeeding Awareness Month.			X	
4. Continue to distribute breastfeeding educational materials to WIC clients.			X	
5. Review and make recommendations regarding proposed legislation or policies addressing breastfeeding.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

DWCNS is continuing to work with the University of Virginia (UVA) to host the web-based training course in lactation management through February 2009. Participation and evaluations are tracked through the web site. Revisions to the site's content will be made if necessary. To date, there have been 656 registered users. UVA will continue to send monthly reports to DWCNS with necessary feedback.

VDH's Statewide Breastfeeding Advisory Committee is continuing to make efforts to gain wider representation from other areas such as workplace, insurance companies, and day care centers. The committee is in the process of developing the mission and vision statements, as well as the logo.

DWCNS is actively managing the Breastfeeding Peer Counselor Program throughout each of the 35 health districts in the Commonwealth. Currently, DWCNS has 37 breastfeeding peer counselors hired. DWCNS is continuing to work through a temporary employment agency to hire and pay the peer counselors. District WIC cffices are using the Loving Support Breastfeeding Curriculum to train peer counselors. DWCNS continues to seek training opportunities as well as develop continuing education for the peer counselors in order to keep them abreast of the latest research in the field of lactation management.

The Division's Breastfeeding Awareness Media Campaign was met with great success. To date, the Comcast Video On Demand has been the number one viewed Video On Demand in the Metro Richmond area.

c. Plan for the Coming Year

Based on the success of the web-based training on lactation management developed in 2007, the Division of WIC & Community Nutrition Services (DWCNS) will be contracting with the University of Virginia (UVA) to develop and host another web-based training course on Breastfeeding the Preterm and Near Term Infant. This course will be linked to the same URL as the previous course and participants will be able to access both. This new course will also offer free continuing medical education units to physicians and free continuing education units to other health care professionals (nurses, dietitians, pharmacists, etc.).

VDH's Statewide Breastfeeding Advisory Committee will continue to hold quarterly meetings. The smaller working committees (data, media, policy, education, and baby-friendly hospital initiative) will work to develop short term goals. One of the impending goals of the policy subcommittee will be to develop a position paper on obesity and breastfeeding that will be disseminated throughout the Commonwealth.

Given the success of the Comcast Video on Demand, DWCNS will continue to campaign until September 30, 2008. This media marketing campaign will work to increase the breastfeeding rates throughout the Commonwealth.

A press release for Breastfeeding Awareness Month (August 2008) is being developed and will be available to local agencies.

DWCNS will continue to support the Breastfeeding Peer Counselor program while working through a temporary employment agency to hire and pay the peer counselors. DWCNS will continue to develop training and host annual video conferences throughout the Commonwealth.

A press release for Breastfeeding Awareness Month (August 2009) will be developed and made available to local agencies.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	96.2	97.3	96.8	96.2	96.7
Numerator	94601	99039	99359	101886	104715
Denominator	98328	101781	102647	105890	108261
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
Data from the Virginia Early Hearing Detection and Intervention System, 2007 and the number of provisional occurrent births from Virginia Health Statistics, 2007.

Notes - 2006
Data from the Virginia Early Hearing Detection and Intervention System, 2006 and the number of occurrent births from Virginia Health Statistics, 2006.

Notes - 2005
Data from the Virginia Early Hearing Detection and Intervention System, 2005 and the number of occurrent births from Virginia Health Statistics, 2005.

a. Last Year's Accomplishments
During FY 07, the Virginia Early Hearing Detection and Intervention (VEHDI) Program continued to administer the state's newborn hearing screening program as required by the Code of Virginia. The VEHDI Program carried out the following activities: (1) continued to submit quarterly reports to hospitals; (2) submitted an annual status report to hospital CEOs; (3) conducted a VEHDI Program evaluation; (4) produced and disseminated an annual report; (5) produced and disseminated a new hospital brochure for parents; (6) continued to collaborate with the VDH Office of Information Management (OIM) to redesign the Virginia Infant Screening and Infant Tracking System (VISITS) application; (7) completed a VISITS II requirements document and the initial project charter; (8) continued networking with other state programs in bordering states to further explore reporting arrangements for resident newborns born in neighboring states; (9) provided technical assistance and training efforts for hospital staff, primary medical care providers, and audiologists to improve newborn hearing screening, referrals, and reporting; and (10) exhibited VEHDI Program displays at one Virginia Chapter, American Academy of Pediatrics and the Virginia Pediatric Society (VaAAP) Conference.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enhance, implement, and evaluate the Virginia Early Hearing Detection and Intervention Program.				X
2. Maintain and improve the Virginia Infant Screening and Infant Tracking System database.				X
3. Provide training for hospital staff.				X
4. Provide hospitals with quarterly updates on program strengths and areas of need.				X
5. Provide annual report to hospital CEOs.				X
6. Monitor all newborn hearing screenings and ensure retesting as needed.				X
7. Monitor hearing screening for out of hospital births.				X
8. Collaborate with other states to track resident infants born in border states.				X
9. Review and make recommendations regarding proposed				X

legislation or policies addressing newborn hearing screening and access to services.				
10.				

b. Current Activities

During FY 08, the VEHDI Program continued to be administered as required by the Code of Virginia and carried out the following activities: (1) reached an all time high screening rate of 99.7% in 2007; (2) hospitals continued to screen all newborns for hearing loss prior to discharge and to report required data through VISITS, the web-based integrated tracking and data management system; (3) hospitals continued to receive quarterly reports on their screening and follow-up rates; (4) the VEHDI Program redesigned current methods to address the need for technical assistance and training efforts for hospital staff, primary medical care providers, and audiologists to improve newborn hearing screening, referrals, and reporting for the redesign of VISITS; (5) continued networking with other state programs and bordering providers to facilitate reporting of resident infants born in neighboring states; and (6) applied for funding from the HRSA Universal Newborn Hearing Screening and Intervention grant to support activities that will reduce the number of infants who are missed; provide additional staff support; increase the number of infants screened who are born outside of hospitals; and promote the VEHDI Program among health care professionals.

An attachment is included in this section.

c. Plan for the Coming Year

In FY 09, the VEHDI Program will: (1) continue to be administered as required by the Code of Virginia; (2) continue to train hospital staff; (3) disseminate quarterly status reports to hospitals; (4) disseminate annual reports to hospital CEOs; (5) initiate site visits to hospitals; (6) continue to focus on children lost to follow up/lost to documentation; (7) advocate for screening and follow up for Virginia resident infants not born in Virginia hospitals; (8) assess the training needs of birthing centers and certified professional midwives to fulfill VEHDI Prpgram reporting requirements; (9) collaborate with hospital administrators to develop a plan to provide parents with VEHDI Program contact information before discharge; (10) conduct ongoing targeted interventions for hospital screening staff who are consistently noncompliant in data reporting; (11) continue to be involved in Virginia Child Health Information Systems Integration Project (VaCHISIP) collaborative activities, which include participating on Project Steering Committee and End User Groups; (12) improve VISITS II authenticated role-based web access reporting efficiency, quality of data, and security for audiologists and primary care providers; (13) improve the tracking and surveillance of program-targeted conditions (i.e., children with hearing loss, birth defects, risk for developmental delay) using VISITS II data; (14) disseminate timely and comprehensive data to healthcare professionals, policymakers, and other stakeholders; (15) improve Care Connection for Children case ascertainment; and (16) complete a feasibility study on linkages with other statewide child health databases (e.g., Immunization Registry, WIC, and Medicaid). Four VEHDI Program staff will continue to be supported by Title V funding.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	5	5	5	5	5
Annual Indicator	6.4	6.4	7.3	7.3	7.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4.9	4.9	4.8	4.8	4.8

Notes - 2007
State survey data not available.
Data from the National Survey of Children's Health, Released 2005.

Notes - 2006
State survey data not available.
Data from the National Survey of Children's Health, Released 2005.

Notes - 2005
State survey data not available.
Data from the National Survey of Children's Health, Released 2005.

a. Last Year's Accomplishments
Annual data regarding health insurance status of children has not been updated. The Urban Institute, under contract for the Virginia Health Care Foundation, did an analysis of Current Population Survey data and estimated that 96,000 children remain eligible but not yet enrolled for publicly sponsored health insurance programs.

VDH continued to collaborate with state and local partners. VDH programs continued integrating outreach, education, and application assistance where feasible. VDH participated in the state mandated Children's Health Insurance Advisory Committee.

The WebVISION-FAMIS application link continued to be used by local health departments since statewide implementation began September 2005. The application for pregnant women for FAMIS MOMS, which can provide coverage for women up to 185% of the federal poverty level was integrated into the child health insurance program.

Information regarding publicly supported children's health insurance programs (FAMIS programs for Medicaid and SCHIP) was distributed through the Governor's New Parent Kit.

In FY 07, seven health districts -- Alexandria, Cumberland Plateau, Lenowisco, Norfolk, Piedmont, Roanoke, and Virginia Beach -- used Title V funding to support efforts to screen and help enroll children in FAMIS programs.

VDH continued efforts of the state Early Childhood Comprehensive Systems Grant (ECCS) from the MCHB for implementation activities. The Virginia ECCS began integrating activities with other early childhood planning efforts championed by the Governor's Office.

Healthy Child Care Virginia (HCCV) mailed two newsletters to over 10,000 child care providers with information regarding children's health insurance programs and the importance of a medical home. These
topics are part of the child care health consultant trainings and were included in the Medication Administration Training curriculum. HCCV has worked with Head Start through association meetings and the Health
Advisory committee to provide relevant updates regarding health insurance programs for children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with partners to increase enrollment in state sponsored health insurance programs.		X		
2. Participate in initiatives and coalitions aimed to reduce uninsured rates.				X
3. Fund local health districts for outreach and enrollment activities.		X		
4. Support surveillance, monitoring, and dissemination of data related to children's health and insurance status.				X
5. Maintain and enhance data system enhancement to generate public insurance application for potential eligibles served in local health districts.		X		
6. Review and make recommendations regarding proposed legislation or policies addressing children's access to healthcare.				X
7.				
8.				
9.				
10.				

b. Current Activities

VECCS will continue with implementation of its strategic plan. In late 2006, the Governor's Office sponsored an integrated planning session for all early childhood stakeholders to merge multiple strategic plans into one umbrella plan. VECCS staff coordinated this effort working with technical assistance from Dr. Dean Clifford. The Governor's initiative on universal pre-Kindergarten has focused early childhood systems integration very heavily on early care and education, with less emphasis on health services. The VECCS project continued to support these efforts and provides consultation on clinical and public health issues, including the importance of insurance coverage.

VDH has continued to collaborate with both private and public sector partners on state and local levels. VDH has maintained efforts to institutionalize outreach, education, and application assistance for public health insurance programs. VDH has continued to participate in the state mandated Children's Health Insurance Advisory Committee.

The WebVISION-FAMIS application has been supported. Since statewide implementation in September 2005, 2,060 children have been identified by local health districts as potential eligibles and 722 have been successfully enrolled. Nearly all health districts (31) have used the link.

In FY 08, four health districts (Alexandria, Norfolk, Roanoke, and Virginia Beach) used part of their Title V allocation to screen and help enroll children in public health insurance programs.
An attachment is included in this section.

c. Plan for the Coming Year

VDH will continue to collaborate with both public and private sector partners on state and local levels to help identify barriers to obtaining and using health insurance and work through state and local programs to assist families who may be eligible for publicly sponsored health insurance programs to apply for these programs.

VDH will continue to support the WebVISION-FAMIS application and to provide updates and technical assistance as needed.

In FY 09, five health districts (Alexandria, Cumberland Plateau, Norfolk, Roanoke, and Virginia Beach) will use part of their Title V allocation to screen and help enroll children in public health

insurance programs.

Healthy Child Care Virginia (HCCV) plans to provide updates through the child care provider newsletter and Head Start meetings.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				30	30
Annual Indicator			31.3	32.5	32.4
Numerator			27836	28822	27881
Denominator			88978	88702	86033
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	30	29	29	29	28

Notes - 2007
Data from WICNet, 2007.

Notes - 2006
Data from WICNet, 2006.

Notes - 2005
Data from WICNet, 2005.

a. Last Year's Accomplishments
The Division of WIC and Community Nutrition Services (DWCNS) continued the commitment to reduce childhood obesity in 2007. All health district WIC programs were required to submit at least three objectives to accomplish the goal of reducing the percentage of overweight WIC children between ages 2-5 by 5%. This will remain a goal for the Virginia WIC Program and activities supported by DWCNS will continue to support the message of good nutrition and physical activity.

DWCNS trained 271 participants from around the Commonwealth including local WIC staff, as well as representatives from diverse groups such as Head Start, Virginia Cooperative Extension staff, and YMCA staff in the I Am Moving, I Learning program. The training was a train-the-trainer program in which participants were required to go back into their communities to train others on how physical activity and good nutrition can be incorporated into all aspects of life and into any environment with little to no funding.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Continue to promote healthy eating/healthy weight to WIC families.			X	
2. Provide educational materials on healthy weight to WIC families.			X	
3. Require district health departments to address healthy weight in their WIC Service Plans.				X
4. Review and make recommendations regarding proposed legislation or policies addressing healthy lifestyles including nutrition and physical activity issues.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Division of WIC and Community Nutrition Services (DWCNS) is currently conducting a follow-up evaluation of the I Am Moving, I Learning training effort to determine if participants are conducting local trainings, how communities are using the program and the establishment of local partnerships.

In August 2007, health district WIC programs implemented "WIC Kids Starting on the Right Page". This initiative promotes reading to children as well as promoting good nutrition and physical activity. The books selected for the program have nutrition and physical activity messages. Books are read to the children during nutrition education groups facilitated by WIC staff at local health districts. At the conclusion of the class, the children receive their own copy of the book that was read.

In keeping with the commitment to reduce obesity rates in WIC children, DWCNS requires that all health districts develop objectives in their annual WIC services plans to reduce childhood obesity in children ages 2-5 by utilizing state approved nutrition education curricula and materials. DWCNS continues implementation of the CHAMPION initiative through the development of a strategic state plan for obesity prevention; fostering environments for collaboration and partnerships; identifying surveillance and data resources; and promoting evidence-based interventions focused on nutrition and physical activity education, media intervention, community involvement, and public policy
An attachment is included in this section.

c. Plan for the Coming Year
Local health districts are expected to continue to develop objectives toward the goal of reducing childhood obesity in WIC children ages 2-5.

DWCNS will also purchase education materials and developing lesson plans which emphasize parenting skills in the areas of good nutrition and physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				6.5	6.4

Annual Indicator			7.0	6.5	6.3
Numerator			7288	6932	6632
Denominator			103830	106474	105349
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	6.2	6.1	6	5.9	5.8

Notes - 2007
2007 provisional data. Virginia is still using the old birth certificate, so indicator measures women who ever smoked during pregnancy.

Notes - 2006
2006 data from birth certificates. Virginia is still using the old birth certificate, so indicator measures women who ever smoked during pregnancy.

Notes - 2005
Data from 2004 birth certificates. Data on smoking in third trimester is not available. Data are percent women reporting smoking throughout pregnancy from birth certificate data, 2004.

It is anticipated that Virginia will use the 2003 standard birth certificate in 2007. At that point, this measure can be computed directly.

a. Last Year's Accomplishments
Data from 2006 birth certificates does not document smoking in the third trimester; therefore, Virginia provides data from birth certificates that indicates smoking during pregnancy.

All family planning and prenatal clinics provide guidance to prenatal women regarding the risk of smoking to the neonate, infant, woman, and to her family. This education is documented on the prenatal record.

WIC, many local health departments, and the Regional Perinatal Councils (RPC) made special efforts to reduce the incidence of smoking by providing pregnant women with early entry into prenatal care, which includes discouraging smoking and promoting good nutrition and increased physical activity. Local health departments served approximately 14,267 maternity patients in CY 2007.

Smoking cessation programs were conducted by appropriate VDH programs. RPCs initiated programs to decrease smoking during the perinatal period.

•RPCs in regions 1, 2, and 6, have promoted a program entitled, "Centering Pregnancy". Within this program, prenatal care is delivered to groups of women that actively participate in the monitoring of their pregnancy. These women join together for group education and discussion regarding ways to ensure a positive pregnancy outcome. The discussion covers smoking concerns for the mother and fetus and the newborn, as well as the effects of second-hand smoke and methods to reduce or stop smoking.
•Region 2 taught the 5 As of the smoking cessation program in a train-the trainer session to hospitals, health departments, and private perinatal care providers.
•Region 3 trained 33 lay health advisors on ways to discuss smoking cessation with pregnant women in their communities.

•Region 6 hosted a perinatal conference and presented evidence-based information pertaining to substance abuse during pregnancy to 160 healthcare professionals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide guidance to women in the family planning and prenatal clinics regarding the risk of smoking.		X		
2. Provide case management to pregnant women and refer them to smoking cessation programs.	X			
3. Provide smoking cessation programs through appropriate VDH's programs.	X	X		
4. Review and make recommendations regarding proposed legislation or policies addressing smoking and the availability of cessation programs.				X
5. Facilitate the approved objectives of the Sudden Infant Death Syndrome task team.		X		X
6. Focus all RPCs, through FIMR, to monitor smoking and to initiate smoking cessations programs sensitive to the culture of individual areas within the state.	X			X
7. Initiate evaluation of PRAMS data to provide another benchmark defining smoking within the perinatal population of Virginia.				X
8. Revise and disseminate information on smoking cessation in the Perinatal Guidelines and Resource Manual used by local health departments.	X			X
9.				
10.				

b. Current Activities

In 2006, birth certificate data reveals that 6.5 percent of women self-reported smoking during pregnancy. This reflects a statistically significant downward trend in smoking rates from 8.97% in 1999 to 6.5% in 2006.

The fetal infant mortality review (FIMR) process has been utilized by RPCs as a method to analyze issues surrounding infant death. As a result, RPCs recognized the need to educate the public on methods of creating a safe sleep environment for the infant, which included smoking cessation and the reduction of second-hand smoke.

A statewide task force was convened to conduct an evaluation of SIDS programs and outcomes. The group agreed that information pertaining to safe sleep environments is the key to reducing the incidence of SIDS and/or SUID within the state. This work includes a clear message to reduce or stop smoking during pregnancy and to continue this behavior throughout life.

The Resource Mothers Program and Virginia Healthy Start Initiative (VHSI) screens pregnant women for smoking and provides counsel and support of their efforts to stop smoking.

An attachment is included in this section.

c. Plan for the Coming Year

DWIH will facilitate objectives of the Sudden Infant Death Syndrome workgroup following evaluation of the SIDS survey results. A survey is being conducted to compare and contrast the

recommendations of American Academy of Pediatrics (AAP) to the current "Back to Sleep" practices of nursing, staff orientation, and procedures at each birth facility within Virginia. The AAP recommendations include the assessment of smoking during hospitalization. Analysis of the survey results will be presented to this workgroup and a statewide plan will be developed with input from this group.

DWIH will focus the efforts of all RPCs, through FIMR, to monitor smoking and to initiate smoking cessation programs sensitive to the culture of individual areas within the state. FIMR information is documented in a central database that will allow for monitoring of smoking as an issue with the individual mortality and to follow recommendations of the consortium to action.

DWIH will revise and disseminate information on smoking cessation in the Perinatal Guidelines and Resource Manual used by local health departments.

DWIH will provide input into the agency's Quality Assurance Committee on the 5 As approach to smoking cessation in the hope that it will be adopted as the standard of care.

The Resource Mothers Program will provide follow-up information to the SIDS Mid-Atlantic Alliance and the March of Dimes on staff implementation of the 5 As and on the teen client outcomes.

VHSI staff will continue to assess for tobacco use during pregnancy and the interconceptional period; provide smoking cessation education and counseling to women who smoke; educate women on the hazards of second hand smoke for infants and children; and provide referrals to smoking cessation programs. Data on incidence and change in behavior based on the implementation of this curriculum will be available at the end of FY 09.

Healthy Start and Resource Mothers clients will continue to receive counseling based on the "I Am Concerned" curriculum. In FY 07, "I Am Concerned: A Brief Intervention for the Primary Prenatal Care Setting" curriculum was implemented with Healthy Start and Resource Mother clients identified as using substances during pregnancy. In FY 2007, the Resource Mothers program reported that 212 teens acknowledged that they smoked early in their pregnancies. By delivery, 76 had stopped smoking. VHSI provided case management services to 564 high-risk perinatal women.

DWIH and the OFHS will initiate the evaluation of preliminary PRAMS data to provide another benchmark defining smoking within the perinatal population of Virginia. PRAMS data will become available to Virginia in 2009.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	5.8	5.8	5.8	5.4	5.4
Annual Indicator	7.7	7.0	6.4	6.2	5.4
Numerator	39	36	34	33	
Denominator	508355	517261	527200	528114	
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	5.2	5.2	5.2	5.2	5.1

Notes - 2007
Data for 2007 not yet available. Entry is an estimate based on trend.

Notes - 2006
2006 data from death certificates and 2006 NCHS population estimates.

Notes - 2005
2005 data from death certificates and 2005 NCHS population estimates.

a. Last Year's Accomplishments
The Division of Injury and Violence Prevention (DIVP) used a combination of state general funds and federal Title V and SAMHSA funds to support suicide prevention efforts in the Commonwealth. DIVP used Title V funding to supply participant materials sufficient to train 1,300 individuals in the two-day Applied Suicide Intervention Skills Training (ASIST). DIVP was also able to provide an additional 118 implementation kits to support middle and high schools in implementing the SOS: Signs of Suicide program. In 2007 alone, over 2,000 students were exposed to the program, which teaches the warning signs that a peer may be in crisis and provides information on connecting that peer with proper help. In January 2007, Virginia became one of the first states in the nation to host a training-for-trainers in safeTALK, which is an evidence based suicide prevention education program. The VDH-sponsored event certified 24 individuals to conduct the three-hour training and as a result over 2,500 individuals have been exposed to safeTALK. DIVP continues to offer free youth suicide prevention trainings to schools and communities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote staff gatekeeper training using the evidence based ASIST, Safe Talk, and QPR programs.				X
2. Provide resources and training to initiate implementation of Signs of Suicide and evidence based secondary school suicide assessment and prevention program.		X		
3. Coordinate statewide education to promote recognition of warning signs and encourage help-seeking.		X		X
4. Review and make recommendations regarding proposed legislation or policies addressing suicide prevention and access to services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
DIVP continues to disseminate educational materials on suicide risk recognition and how to seek help. DIVP continues to coordinate statewide gatekeeper training utilizing several evidence-based models. Community-based youth suicide prevention/early intervention initiatives are taking

place in four regions of Virginia as a part of a SAMHSA Cooperative Agreement. Additionally, VDH has organized the Virginia Network of Suicide Prevention Coalitions to provide technical assistance, information, and training to localities involved in suicide prevention initiatives.
An attachment is included in this section.

c. Plan for the Coming Year
DIVP has applied for funding for an additional three years under the current SAMHSA Cooperative Agreement. If funded, DIVP plans to heighten prevention activities in the rural counties surrounding Richmond and southwest Virginia as part of a targeted effort that currently involves the Harrisonburg area, Central Virginia, middle Peninsula and Rappahannock-Rapidan regions of Virginia. Additionally, DIVP will continue its work with James Madison University to coordinate the efforts of college campuses to effectively address student mental wellness issues.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	90	90	90	91	91.5
Annual Indicator	87.9	87.5	85.2	85.3	83.7
Numerator	1301	1222	1191	1214	1235
Denominator	1480	1396	1398	1423	1475
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	91.5	92	92	92.5	92.5

Notes - 2007
Data from 2007 provisional birth data and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.
For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates" based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

Notes - 2006
2006 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.
For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for high-risk deliveries and neonates" based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

Notes - 2005
2005 data from birth certificates and licensure & certification listing of Level III/IV facilities. Invalid birthweights and invalid hospital codes were excluded from the measure.
For 2005 and forward, stricter criteria was used for determining which hospitals are "facilities for

high-risk deliveries and neonates" based on the state regulations for licensure of hospitals at the specialty and subspecialty levels of infant care (defined for the measure as Level III and Level IV hospitals).

a. Last Year's Accomplishments
In Virginia, 85.3 percent of very low weight births occurred at facilities for high-risk neonates in 2006, which is moving toward the target of 90 percent.

RPCs facilitated the following:

•Maternal and newborn transport data was reviewed to evaluate risk appropriate care for women and infants.
•Through transport reviews between perinatal referral centers and the transferring facility, issues were discussed and plans enacted to improve neonatal transport.
•RPCs facilitated these meetings in an effort to remain knowledgeable about access to care and services within individual regions.
•RPCs offered the STABLE program, which educates hospital providers on stabilization of the neonate, along with the safe and appropriate transport of high-risk maternity patients and/or their newborns.
•Regions compared and contrasted transport data in an effort to remain knowledgeable about perinatal services available in the regions.
•RPC 4 collaborated with Children's Hospital of University of Virginia to host the annual NETS Day Conference with 80 participants.
•RPC 6 organized a maternal transport work group to improve access to care in areas without maternal and infant health providers. The group provided consultation on regional needs, resources, and trends in health care for women and infants.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Conduct fetal infant mortality reviews (RPCs) to identify barriers to care and make systems changes to address barriers.				X
2. Data pertaining to transport will be monitored and confirmed with health district directors for information sharing and issues resolution.				X
3. VHSI local site plans include developing relationships with programs and clinics that provide pregnancy-testing services to increase referrals early in pregnancy.		X		X
4. The Division of Women's and Infants' Health staff will also serve on the regulatory work group that will review the hospital neonatal regulations during the next year.				X
5. As trending data becomes apparent through FIMR concerning transport and/or access to care, regional activities will occur.	X	X		X
6. Review and make recommendations regarding proposed legislation or policies addressing availability and access to appropriate care.				X
7.				
8.				
9.				
10.				

b. Current Activities

The RPCs continue to review maternal and newborn transport data to evaluate risk appropriate care for women and infants. These transport reviews provide the forum for sharing evidence-based practices pertaining to individual patient outcomes of care and for discussing concerns between the transferring and receiving obstetrical or neonatal care facility. The transport reviews are scheduled to occur bi-annually or annually, as requested by the facility.

DWIH staff have been involved in preliminary research and drafting the proposed revised neonatal levels of care regulations.

DWIH directed the RPCs to conduct fetal infant mortality reviews. The RPCs will identify barriers to care and make systems changes to address those barriers. The FIMR process includes an evaluation of the system of healthcare delivery for mothers and infants. As a result, if issues pertaining to transport are made, recommendations are made to all hospitals in an area. These recommendations are made to increase knowledge of providers that may reduce infant deaths. Education continued in the areas of STABLE and NRP for healthcare providers, although the majority of hospitals recognize these educational offerings as an ongoing competency responsibility of the hospital and the need for this education has decreased.

An attachment is included in this section.

c. Plan for the Coming Year
FIMR will become the primary focus of the RPCs. As trend data concerning transport and/or access to care become apparent, regional activities will occur. Access to care will be monitored. Access to care is not an issue in some areas of the state but remains a concern in other areas. Hospital-based neonatal transport reviews will no longer be funded by the RPC contract.

The Division of Women's and Infants' Health staff will also serve on the regulatory work group that will review the hospital neonatal regulations during the next year and prepare revisions to the levels of care.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	89	90	90	91	91
Annual Indicator	84.8	84.8	84.6	83.5	83.5
Numerator	85259	88054	88409	88867	87922
Denominator	100561	103830	104488	106474	105349
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	91	91	91	92	92

Notes - 2007
2007 provisional birth certificate data.

Notes - 2006
Data from 2006 birth certificates.

Notes - 2005
Data from 2005 birth certificates.

a. Last Year's Accomplishments
In 2006, Virginia had 83.5 percent of infants born to women who received prenatal care in the first trimester, with the target being 91 percent. Within the Virginia Department of Health, 22 local health departments provide prenatal care; others assist women in obtaining direct medical services with a local provider and refer those eligible for Medicaid.

RPCs work to increase the percentage of women receiving early prenatal care, as indicated by the following activities:

•RPC 1 and RPC 3 conducts Community Voices program in which lay outreach workers are trained to educate community participants on the importance of early and adequate prenatal care.
•RPC 3 is continuing the Beds and Britches Program, a prenatal care incentive project that rewards women for keeping prenatal appointment, active participation in childbirth education offerings, and other demonstrations of good prenatal care activities.
•RPC 6 coordinates consultations with groups of concerned stakeholders in two communities seeking funding to improve access to health care for women and infants. RPC 6 developed obstetrical triage guidelines and maternal referral information forms. They also presented on this topic at the Infant Mortality Summit in October 2007. RPC 6 convened a Low Birth Weight Committee to develop a comprehensive strategy by July 2008 to increase awareness of the factors related to LBW births with a focus on provider and community behavior.

VHSI local site plans include developing relationships with programs and clinics that provide pregnancy-testing services to increase referrals early in pregnancy. Referral systems established with Medicaid eligibility workers, Community Health Centers, health department clinics, and private physicians will be maintained.

Resource Mothers conduct outreach to teens and those serving teens in order to increase awareness of the need for prenatal care in the first trimester and of organizations that teens can access for prenatal care. Of those enrolled in 2007, 64% were enrolled during the first trimester.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Educate providers on how to better serve low income women and link them to community resources including health insurance.		X		
2. Educate public on the importance of early prenatal care.			X	
3. Provide education and training to providers on topics that support adequate prenatal care.		X		
4. Provide funding to district health departments to support prenatal care.		X		
5. Through the FIMR and Maternal Death Review process, entry into prenatal care will be monitored, issues identified, and community-based recommendations implemented and evaluated for effectiveness.		X		
6. VHSI local site plans include developing relationships with	X			

programs and clinics that provide pregnancy-testing services to increase referrals early in pregnancy.				
7. Actively investigate all available data sources in an effort to understand barriers for initiating prenatal care within the first trimester compare and contrast healthcare providers' location to identify gaps.		X		
8. Review and make recommendations regarding proposed legislation or policies addressing access to care.				X
9.				
10.				

b. Current Activities
The RPCs have demonstrated commitment to improving the initiation of prenatal care by the following activities:

•RPC 1 initiated the "BABY Basics program", which is an educational pilot with obstetricians in the area. The pilot is funded by MOD and Speedway Children's Charities. RPC 1 provided input regarding content and revisions to the production company. Pregnant women have reported the book to be helpful.
•RPC 2 collaborated with the community to implement Community Voices by training lay health workers to articulate the importance of early and adequate prenatal care. This program aims to increase community awareness on the disparities of African-American infant morbidity and mortality and the importance of early and adequate prenatal care by using lay health workers.
•RPC 5 Consortium members presented on preconception health practices at the Virginia Occupational Health Nurses August meeting.
•RPC 7 FIMR expanded to include Virginia Beach Health District. They also hosted the Mid-Atlantic Neonatal and Perinatal Summit in November 2007.

Resource Mothers conduct outreach to teens and those serving teens in order to increase their awareness of the need for prenatal care in the first trimester and of organizations that teens can access for prenatal care. Of those enrolled in 2007, 64% were enrolled during the first trimester, which is above the HRSA benchmark of 60% of teens enrolling in prenatal care within the first trimester.

An attachment is included in this section.

c. Plan for the Coming Year
In 1990, 84.7% of women began care in the first trimester and 83.5% of women in 2006 received care during the first trimester. This knowledge will be the focus to discover reasons for the barriers and conditions affecting women receiving care in the first trimester.

Through the FIMR and Maternal Death Review process and PRAMS data, entry into prenatal care will be monitored, issues identified, and community-based recommendations implemented and evaluated for effectiveness.

Early entry into prenatal care will allow for the assessment and development of medical/social care plan that may result in improve outcomes of maternal and neonatal outcomes. DWIH and DMAS are investigating a proposal to implement a reimbursement schedule for the use of assessment tools in the area of perinatal depression. A thorough assessment of screening tools was done and a list of recommended tools has been submitted to DMAS. The reimbursement change will reimburse for the screening and referrals, if appropriate, of perinatal depression. When recommendations are confirmed, DWIH and DMAS will partner to provide education and technical support to implement the recommendations.

The Resource Mothers Program has the goal of early and regular prenatal care. Each local site's

plan for enhancing first trimester enrollment is reviewed annually in relation to the local site's accomplishment the previous year; revisions to the site work plan are made accordingly. Enrollment activities and the birth outcomes are monitored.

VHSI local site plans include developing relationships with programs and clinics that provide pregnancy-testing services to increase referrals early in pregnancy. Referral systems established with Medicaid eligibility workers, Community Health Centers, health department clinics, and private physicians will be maintained.

All local health departments offer pregnancy testing and, if positive, provide patient counseling and referral for prenatal care within two weeks.

D. State Performance Measures

State Performance Measure 1: *The percent of children and adolescents who have a specific source of ongoing primary care for coordination of their preventive and episodic health care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	80	84	84	84	84
Annual Indicator	75	85.1	85.1	85.1	85.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	84	84	84	85	85

Notes - 2007
2007 data not available. Estimate based on data from the National Survey of Children's Health released 2005.
Question:
Do you have one or more person(s) you think of as your child's personal doctor or nurse ?(S5Q01)

Notes - 2006
2006 data not available. Estimate based on data from the National Survey of Children's Health released 2005.
Question:
Do you have one or more person(s) you think of as your child's personal doctor or nurse ?(S5Q01)

Notes - 2005
2005 data not available. Estimate based on data from the National Survey of Children's Health released 2005.
Question:
Do you have one or more person(s) you think of as your child's personal doctor or nurse ?(S5Q01)

a. Last Year's Accomplishments
In FY 07, OFHS funded health districts that promote access to medical homes through case management, assistance with getting and using public health insurance programs, and in some districts provision of child health services for clients with no other resources. Alexandria,

Cumberland Plateau, Lenowisco, Norfolk, Piedmont, Roanoke, and Virginia Beach are using Title V funds to work on these goals.

VDH has collaborated with the Virginia Chapter of the American Academy of Pediatrics to promote the concept of Medical Home. Part of this collaboration included working with Virginia Commonwealth University to sponsor the Bright Futures web-based training for continuing medical education/continuing education units. This web-course has a module on the concept of Medical Home.

VDH programs such as Virginia Early Hearing Detection and Intervention, the Virginia Newborn Screening Services program, and Care Connection for Children continued efforts to link newborns to medical homes as needed.

Healthy Child Care Virginia (HCCV) mailed two newsletters to over 10,000 child care providers with information regarding children's health insurance programs and the importance of a medical home. These
topics are part of the child care health consultant trainings and were included in the Medication Administration Training curriculum. HCCV has worked with Head Start through association meetings and the Health
Advisory committee to provide relevant updates regarding health insurance programs for children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Fund local health districts to assist families in finding and utilizing a medical home.		X		
2. Participate in initiatives and coalitions that aim to increase utilization of medical homes.				X
3. Continue surveillance, monitoring, and dissemination of data related to utilization of care.				X
4. Work with the AAP to promote the medical home concept for all children and adolescents.				X
5. Work with school nurses to promote the medical home concept to school children and their parents.				X
6. Collaborate with state Early Childhood Comprehensive Systems Project to implement a strategic plan for assurance of medical and dental homes.				X
7. Provide information to parents about the medical home concept through the Governor's New Parent Kit.		X		
8. Review legislation and policies addressing health care access.				X
9. Continue participation in the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services to promote medical homes for CSHCN.				X
10.				

b. Current Activities

The Division of Child and Adolescent Health (DCAH) is participating with the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC). The DCAH Director is on a work group focused on promoting medical home and a system of care for CSHCN identified through newborn screening. Efforts to date have centered on identifying and promoting helpful tools that primary and specialty care providers can use to better communicate with each other, and include the family as an active partner.

In FY08, OFHS funded Alexandria, Norfolk, Roanoke, and Virginia Beach to promote access to

medical homes.

DCAH Title V staff continues to promote the medical home concepts in all partnerships. VDH has continued to partner with the Virginia Chapter of the American Academy of Pediatrics to promote the concept of the Medical Home. Sponsorship of the Bright Futures web-based training that contains information about the Medical Home concept and offers continuing education credits/units has continued.

An attachment is included in this section.

c. Plan for the Coming Year
VDH will continue to promote the concept of the medical home in all DCAH programs and partnerships.

DCAH staff will continue to participate in the New York Mid Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC).

In FY 09, Alexandria, Cumberland Plateau, Norfolk, Roanoke, and Virginia Beach will use part of their Title V allocation to promote access to medical homes.

Healthy Child Care Virginia (HCCV) plans to provide updates through the child care provider newsletter and Head Start meetings.

State Performance Measure 2: *The percent of children who are overweight or obese.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	16	15	14	14	14
Annual Indicator	17.4	31.3	31.3	32.5	32.4
Numerator			27836	28822	27881
Denominator			88978	88702	86033
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	14	14	14	13	13

Notes - 2007
Data from the WIC program database WICNet 2007. Beginning in 2004, overweight/obese was defined as at or above the 85th percentile. Previously, the 90th percentile was reported, so data prior to 2004 are not comparable to current figures.

Notes - 2006
Data from the WIC program database WICNet 2006. Beginning in 2004, overweight/obese was defined as at or above the 85th percentile. Previously, the 90th percentile was reported, so data prior to 2004 are not comparable to current figures.

Notes - 2005
Data from WICNet 2005. Beginning in 2004, overweight/obese was defined as at or above the 85th percentile. Previously, the 90th percentile was reported, so data prior to 2004 are not comparable to current figures.

a. Last Year's Accomplishments
The Division of WIC and Community Nutrition Services (DWCNS) provided Addressing Childhood Overweight II -- I Am Moving, I Am Learning trainings to 271 participants throughout the

Commonwealth. These trainings included local WIC staff, as well as representatives from diverse groups such as Head Start, Virginia Cooperative Extension staff, and YMCA staff. The training was a train-the-trainer program that requires participants to go back into their communities to train others on how physical activity and good nutrition can be incorporated into all aspects of life and into any environment with little to no funding.

DWCNS continued moving forward with its implementation of the CHAMPION (the Commonwealth's Healthy Approach for Mobilization, Inactivity, Obesity, and Nutrition) initiative working towards the goal of a strategic state obesity prevention plan; identifying national and local surveillance and data; and increasing the number of communities implementing evidence-based interventions and best practices in obesity prevention.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide educational materials promoting healthy lifestyles.			X	
2. Participate in coalitions and collaborations aimed at policy and program development to promote healthy nutrition and adequate physical activity.				X
3. Support activities of Virginia Action for Healthy Kids to improve access to healthy foods and increased physical activity opportunities within schools.				X
4. Promote "Eat Smart Virginia", an obesity prevention tool kit.			X	
5. Collaborate with the Department of Education to maintain the website "Health Smart Virginia."		X		
6. Fund and support local health district programs that address childhood obesity.		X		
7. Review and make recommendations regarding policies/legislation addressing obesity.				X
8. Develop and distribute the CHAMPION Report based on the regional meetings addressing prevention and control of obesity.				X
9. Develop and maintain a CHAMPION web site.			X	
10.				

b. Current Activities

DWCNS is currently conducting a follow-up evaluation of the I Am Moving I Learning training effort to determine if participants are conducting local trainings, how communities are using the program, and the establishment of local partnerships.

In keeping with the commitment to reduce obesity rates in WIC children, DWCNS continues to require that all health districts develop objectives in their annual WIC services plans to reduce childhood obesity in children ages 2-5 by utilizing state approved nutrition education curricula and materials. DWCNS continues its implementation of the CHAMPION initiative through the development of a strategic state plan for obesity prevention; fostering environments for collaboration and partnerships; identifying surveillance and data resources; and promoting evidence-based interventions focused on nutrition and physical activity education, media intervention, community involvement, and public policy.

An attachment is included in this section.

c. Plan for the Coming Year

DWCNS will continue its implementation of CHAMPION, as well as seek opportunities for collaboration and partnerships to strengthen statewide obesity prevention efforts by encouraging policy and environmental changes at the local levels; increasing awareness and education regarding overweight and obesity prevention; and promoting evidence-based interventions.

DWCNS will continue to provide outreach to local community coalitions by providing technical assistance and support.

State Performance Measure 3: *The percent of newborns who fail the hearing screening and who receive a diagnosis before three months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	77	81	85	89	93
Annual Indicator	71.0	73.1	71.9	72.0	62.8
Numerator	2161	2139	2158	2087	1851
Denominator	3042	2927	3001	2898	2947
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	95	95	95	95	95

Notes - 2007
The measure was changed for the 2008 Title V Application. The previous measure read: "The percent of newborns screened for hearing loss who receive recommended follow-up services." This measure definition applies to data years 2005 and previous.

The new measure emphasizes the need not only for a follow-up visit but for a diagnosis (hearing loss, normal hearing, etc.) within three months.

Data are from the Virginia Early Hearing Detection and Intervention Program.

Notes - 2006
The measure was changed for the 2008 Title V Application. The previous measure read: "The percent of newborns screened for hearing loss who receive recommended follow-up services." This measure definition applies to data years 2005 and previous.

The new measure emphasizes the need not only for a follow-up visit but for a diagnosis (hearing loss, normal hearing, etc.) within three months.

Data are from the Virginia Early Hearing Detection and Intervention Program.

Notes - 2005
Data are from the Virginia Early Hearing Detection and Intervention Program.

a. Last Year's Accomplishments
During FY 07, the VEHDI Program carried out the following activities: (1) collaborated with the Part C Early Intervention System to track outcomes for those children with hearing loss who were referred to and received Part C services; (2) conducted one teleconference for primary medical care providers on the role of the provider, early intervention, and parent issues; (3) collaborated with CDC and four other states in a program evaluation project that examined the issue of children lost to follow up; (4) supported web-based classes for eight early intervention providers; (4) maintained the hearing aid loan bank; (5) provided training for audiologists during the annual state professional organization meeting; (6) sent quarterly reports to audiologists; (7) revised the

follow up report and disseminated it to 130 audiology facilities; (8) initiated the revision of assessment protocols; (9) established the Virginia Guide By Your Side, a statewide system of trained parent contacts for families of newly diagnosed infants and young children; (10) conducted a program evaluation through a survey of parents with children with hearing loss; and (11) submitted the application for the final year of the HRSA Universal Newborn Hearing Screening and Intervention grant.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer statewide early hearing detection and intervention program.			X	
2. Mail letters to parents and primary care providers regarding screening results and need for follow up.	X			
3. Implement aggressive tracking activities for children lost to follow-up.	X			
4. Collaborate with Part C Early Intervention System to streamline referrals and document outcomes.				X
5. Provide parent-to-parent contact for families of children with hearing loss.		X		
6. Provide training to increase capacity of Part C Early Intervention System to provide appropriate intervention services for children with hearing loss.				X
7. Maintain the Virginia Hearing Aid Loan Bank.	X			
8. Review any proposed legislation and policies that address newborn hearing services.				X
9. Maintain the Guide By Your Side Program.	X			
10.				

b. Current Activities

In FY 08, the VEHDI Program carried out the following activities: (1) updated and disseminated the Parent Resource Directory and Guide; (2) continued to maintain the Hearing Aid Loan Bank; (3) continued to maintain the Virginia Guide By Your Side Program; (4) developed and disseminated an audiological survey to determine the reporting needs of audiologists in order to increase the number of approved audiological facilities; (5) submitted an application for the CDC EHDI grant; (6) sent quarterly reports to audiologists; (7) continued to generate letters to parents and primary care providers for infants who failed initial screening; (8) submitted an application for the HRSA Universal Newborn Hearing Screening Intervention grant; and (9) continued to collaborate with Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Service and the Virginia Department of Education to establish a system for collecting and sharing outcome data for children with hearing loss and birth defects across agencies.

Performance measure results for 2006 reflect a stronger commitment to assure diagnosis. The data results are lower than previous years, which measured any recommended follow up.

An attachment is included in this section.

c. Plan for the Coming Year

During FY 09, VEHDI Program staff will: (1) locate a permanent home for the Virginia Guide By Your Side Program; (2) locate a permanent home for the Hearing Aid Loan Bank; (3) review, adopt, and implement 2007 Joint Committee on Infant Hearing recommendations; (4) produce and disseminate a new health awareness poster for obstetricians, pediatricians, health departments, and birthing centers; (5) focus on recruiting more audiological facilities; (6) provide

training and education activities for primary care providers, audiologists, and early intervention providers; (7) focus on developing a system to track births that occur outside of hospitals in Virginia; (8) focus on developing a system to track births of Virginia residents that occur in states bordering Virginia; (9) complete the surveillance methodology evaluation plan for the VEHDI Program; (10) complete assessment protocols; (11) improve the quality of services provided by the VEHDI Program; (12) assess the feasibility of audiologists entering their own hearing evaluation results into VISITS II; and (13) develop and implement a learning collaborative among primary care providers, audiologists, and hospitals to evaluate the current system and assess the need for modifications.

State Performance Measure 4: *The unintentional injury hospitalization rate for children aged 1-14 per 100,000.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	140	137.5	135	132.5	130
Annual Indicator	125.0	135.2	121.4	124.9	120.1
Numerator	1747	1890	1704	1732	
Denominator	1397075	1397841	1403893	1387023	
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	130	130	130	130	130

Notes - 2007
2007 data not yet available. Entry is an estimate based on trend.

Notes - 2006
Data from Virginia Hospitalization Discharges 2006.

Notes - 2005
Data from Virginia Hospitalization Discharges 2005.

a. Last Year's Accomplishments
Title V funded staff in the Division of Injury and Violence Prevention (DIVP) continued to provide oversight and coordination of the statewide unintentional injury prevention program and to leverage multiple sources of federal funding support for activities.

DIVP fulfilled requests for 475,320 English and Spanish prevention TIP cards, posters, and videos from its resource center. DIVP began issuing two newsletters per year to 2,800 licensed or registered family day homes to share prevention resources and information. DIVP continued to provide training and consultation on injury related data and prevention strategies. A web based injury reporting system was updated to enable access to death and hospitalization data from 1999-2006. An annual report on Virginia's injury deaths and hospitalizations was produced and disseminated and fact sheets with district specific data were provided to the 35 health districts. DIVP staff continued to work with a statewide planning group to develop a state injury prevention plan as part of a CDC cooperative agreement.

The Division awarded mini-grants to 48 community based organizations for bicycle helmet distribution. This effort was combined with various safety events such as school presentations, health fairs, and bicycle safety rodeos during the project period of May through August 2007. In total, 4,500 children received helmets. DIVP also coordinated ten Bike Smart Basics trainings

during 2007, at which 119 health and physical education teachers were trained on the basics of bicycle and helmet safety and encouraged to adopt a bicycle safety unit of instruction as part of their health and PE curriculum.

The Division held a school-based injury prevention workshop February 28-March 2, 2007. With over 275 attendees, the workshop highlighted injury prevention strategies and resources that school personnel could use to improve the safety of their schools and students. Workshop topics include: Internet Safety, Bullying Prevention, Strategies for Student-Led Safety Projects, Playground Safety, Safe Routes to School, Sports Safety, Teen Dating Violence Prevention, Inhalant Abuse, Safe Teen Driving, School Violence Prevention, and Youth Suicide Prevention. The three-day workshop was initiated to compliment the resource, Safe Schools and Safe Students in Virginia: Guidelines and Resources to Improve the Safety of Students in Virginia, which DIVP continued to disseminate to administrators, staff, and parent-teacher associations at K-12 schools. DIVP partnered with the Virginia Department of Education to coordinate a day of injury prevention workshops at the Health and Physical Activity Institute. Workshop topics included: Risk Watch: An Unintentional Injury Prevention Curriculum, Health Smart VA Web Site Tutorial, Bike Smart Basics, Student-Led Safety Projects, Bullying Prevention for Educators, Healthy Teen Relationships, and Statutory Rape Prevention.

The Division conducted three six-hour playground safety awareness trainings using the SAFE Playground Model in Hanover, Manassas, and Roanoke during 2007 for 95 school and child care personnel. DIVP also continued to promote and disseminate CDC's concussion awareness and prevention tool kits to high school coaches and PE programs. DIVP trained 25 schools to implement Risk Watch, an activity-based unintentional injury prevention curriculum for grades K-6. DIVP also continues to disseminate a school safety fair planning kit aimed at helping older elementary school and middle school students independently coordinate school safety fairs with guidance from adults.

DIVP continued to support educators with a web site (www.injuryfreeschoolsva.org) and list server with information, a calendar of related trainings, funding opportunities, school safety guidelines, many free downloadable resources, and an order form to acquire free materials. DIVP also coordinated a full-scale overhaul of the Health Smart VA Web site, www.healthsmartva.org, updating the lesson plans and resource links. In addition to injury and violence, the curriculum resources address nutrition, physical health, mental health, disease prevention, and substance use prevention. The web site is a collaborative effort between the Virginia Department of Health, Virginia Department of Education, and Prince William County Schools to support educators in meeting the Virginia Standards of Learning. The Web site had a total of 1,772,903 hits from January to December.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Coordinate state, community, and school based educational activities relating to the prevention of unintentional injuries.			X	
2. Provide funding and support for health districts' unintentional injury projects.		X		
3. Develop and implement public awareness campaigns.			X	
4. Disseminate safety devices (e.g. child restraints, smoke alarms).	X			
5. Review and make recommendations regarding proposed legislation or policies addressing unintentional injury issues.				X
6.				
7.				
8.				

9.				
10.				

b. Current Activities

DIVP staff continue to coordinate numerous state and community childhood injury prevention projects and provide data, educational resources, and information through a website, resource center, and 1-800 line. DIVP has produced an annual report on injury deaths and hospitalizations that occurred in 2006 with a focus on the five year tends of injury related death and hospitalization in Virginia. DIVP has updated and is promoting VOIRS, an online injury data query system which provides race, age, gender, intent, and location specific information across several mechanisms of injury for the years 1999- 2006. DIVP continues to coordinate a statewide injury prevention planning process, funded through a CDC cooperative agreement, and will be holding an Injury Prevention Symposium in July. DIVP continues to coordinate school injury prevention projects, provide ongoing consultation to schools on injury and violence prevention, and respond to requests for the SAFE SCHOOLS SAFE STUDENTS Guidelines. DIVP collaborated on an Inhalant Abuse Prevention Awareness campaign targeted to parents of middle school-age children and funded the printing of a new inhalant resource for schools. The Inhalant Abuse Prevention: Staff Education and Student Curriculum will be distributed to every school in Virginia. DIVP is managing updates for the Health Smart Virginia! DIVP is also supporting bicycle helmet promotion projects in 90 communities in Virginia.

An attachment is included in this section.

c. Plan for the Coming Year

DIVP will continue to coordinate a wide variety of state-level, community-level, and school based activities to prevent childhood injuries. DIVP is planning a mini-grant opportunity to support schools that implement injury and violence prevention projects that are consistent with the SAFE SCHOOLS SAFE STUDENTS Guidelines. DIVP plans to develop a leadership resource for high school students to initiate and implement injury prevention projects in their schools and communities. DIVP is planning a marketing campaign to widely advertise the Health Smart VA web site to educators. DIVP is also developing a resource for schools to assess and address playground hazards and has provided training as part of a regional school playground improvement project. DIVP will continue work to further prevent youth traumatic brain injury through sports safety and bicycle helmet safety activities.

State Performance Measure 5: *The percent of low income children (ages 0-5) with dental caries.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				12.5	12.4
Annual Indicator		23.2	22.2	22.3	21.3
Numerator		3339	2763	2923	2761
Denominator		14391	12456	13087	12938
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	12.3	12.2	12.1	12	11.9

Notes - 2007

FY07 Head Start Data; State FY 7/1/06-6/30/07

Notes - 2006

FY06 Head Start Data; State FY 7/1/05-6/30/06

Notes - 2005
Data is from the 2004-2005 Head Start Program and represents the percentage of Head Start children (ages 3-5) needing dental treatment. Data also is included from a 2005 VDH study of caries prevalence in Early Head Start children (ages 0-3).

a. Last Year's Accomplishments
The Division of Dental Health (DDH) supported local health department dental programs with Title V funds through providing a dentist to coordinate a quality assurance program, assist with recruitment for local health department dental programs, and orient new dental staff. In FY 2007, on-site quality assurance reviews were provided for dental programs in Roanoke City and Alleghany County. VDH dental clinics served 25,592 individuals in 47,766 visits in FY 07. More than 179,000 clinical services, including 17,000 dental sealants, were provided for these patients at a value of more than $14 million dollars. Eighty-five percent of encounters were for school age children. Training was provided for 100 dental staff in 25 health districts regarding pediatric dentistry and other public health dental topics during a two-day meeting. Additionally, staff was trained regarding pediatric dentistry during a teleconference. Norfolk City, Roanoke City, and Thomas Jefferson Health Districts continued to use Title V funds to help support their dental programs.

A total of 638 dentate children received annual screenings and fluoride varnish applications through the State Oral Health Collaborative Systems Grant. A new partnership initiative was piloted in FY 07 to improve access to education and prevention services for Head Start children. DDH partnered with Virginia Head Start and the Virginia Dental Hygienists' Association to launch "Adopt a Head Start Program".

More than five million citizens, including children of preschool age, consume water that has been optimally fluoridated. DDH provides oversight and monitors the systems for compliance in conjunction with the VDH Office of Drinking Water.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide anticipatory guidance for parents.		X		
2. Provide fluoride varnish application for children.	X			
3. Maintain data collection efforts for evaluation of dental programs.				X
4. Provide training for dental providers.		X		
5. Collaboration with Medicaid regarding covered services.		X		X
6. Collaboration with partners (i.e. WIC, Early Head Start, Head Start) to provide anticipatory guidance or other oral health services.		X		
7. Oral health services are provided to children 0-5 in local health department dental clinics.	X			
8. Review and make recommendations regarding proposed legislation or policies addressing access to dental care.				X
9.				
10.				

b. Current Activities
There have been ongoing trainings and education to dental and non-dental practitioners regarding application of fluoride varnish. Through Preventive Health and Health Services funding the varnish program has been expanded in the Northern Virginia and Eastern Shore regions of the state through contracting with staff to provide varnish and education for these groups.

Virginia was successful in receiving a Targeted Oral Health Systems (TOHS) Grant that will fund a dental hygienist and expand the fluoride varnish program to WIC participants. This opportunity to expand the existing program will provide a much needed emphasis on improving access to dental services for one year-old children who are at high risk for dental disease. The targeted geographic area in Central Virginia will serve as a model for implementing other similar local projects throughout the state.

c. Plan for the Coming Year
In FY 08, DDH will complete the evaluation of the varnish program utilizing three years of data that has been collected at Early Head Start locations.

State Performance Measure 6: *The ratio of dentists to population in underserved areas.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				0.4	0.5
Annual Indicator		0.3	0.3	0.3	0.3
Numerator		1318	1318	950	950
Denominator		4290110	4290110	3690512	3690512
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	0.6	0.7	0.8	0.8	0.8

Notes - 2007
Data is from a 2006 VDH assessment of dentally underserved areas in Virginia and Manpower Analysis. The annual indicator represents the number of general dentists per 1,000 population, where the numerator is the number of general dentists in all dentally underserved areas and the denominator is the total population of all dentally underserved areas in Virginia. The statewide average dentist to population ratio is 1 dentist per 2,472 persons or ~0.5 dentists per 1,000 persons. Areas of need are defined as those areas having a lower dentist to population ratio than the statewide average, and need at least 0.5 additional dentists to meet the state dentist to population ratio.

Notes - 2006
Data is from a 2006 VDH assessment of dentally underserved areas in Virginia. The annual indicator represents the number of general dentists per 1,000 population, where the numerator is the number of general dentists in all dentally underserved areas and the denominator is the total population of all dentally underserved areas in Virginia. The statewide average dentist to population ratio is 1 dentist per 2,084 persons or 0.5 dentists per 1,000 persons. Areas of need are defined as those areas having a lower dentist to population ratio than the statewide average.

Notes - 2005
Data is derived from a 2001 VDH assessment of dentally underserved areas in Virginia. The annual indicator represents the number of general dentists per 1,000 population, where the numerator is the number of general dentists in all dentally underserved areas and the denominator is the total population of all dentally underserved areas in Virginia. The statewide average dentist to population ratio is 1 dentist per 2,084 persons or 0.5 dentists per 1,000 persons. Areas of need are defined as those areas having a lower dentist to population ratio than the statewide average. All areas of need are being reassessed in 2006.

a. Last Year's Accomplishments

The Virginia Dental Loan Repayment program was first implemented during FY 06 and is funded by state general funds. The areas of need were updated in FY 07 to reflect changes in state demographics and population. FY 07 funding provided dental scholarships to twelve VCU students and to eight dentists in the form of loan repayment awards (5 renewals and 3 new contracts). In FY 07, loan repayment awards ranged from $7,602 to $15,204 based on the year that the dentist acquired the loan. During FY 07, there were fourteen practicing dentists with a scholarship or loan repayment service obligation. The fourteen dentists had practices throughout the state in rural and urban areas: six in the Central region (Charles City County, Chesterfield County, Colonial Heights, Henrico County, Hopewell, Richmond City); four in the Southwest region (Bedford County, Martinsville, Tazewell County, Wise County); three in the Eastern region (Isle of Wight County, Newport News, Richmond County); and one in the Northern region. The median Medicaid revenue generated by these dentists under scholarship or loan repayment obligation was $33,402, which is about three times the statewide median.

As part of an ongoing effort to publicize the new loan repayment program, paid advertisements were run for six months in the Journal of the American Dental Association. These monthly ads generated no viable candidates and were discontinued after the six-month trial. Ongoing ads have been published in the Virginia Dental Association Journal since the inception of the program. These have been more fruitful and will be continued.

Dr. Karen Day, Director, Division of Dental Health, serves on the Virginia Medicaid Dental Advisory Committee, which works to increase the number of Medicaid providers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Dental scholarship program for dental students.		X		
2. Provide dental loan repayment program for practicing dentists and dental hygienists.		X		
3. Collaborate with the Office of Health Policy on designation of dental Health Professions Shortage Areas.				X
4. Maintain collaboration with Virginia Commonwealth University's School of Dentistry.				X
5. Recruit dentists to serve in local health departments.				X
6. Analyze data on Medicaid patients seen in underserved areas.				X
7. Review and make recommendations regarding proposed legislation or policies addressing dental practice issues.				X
8. Continue to market the dentist and dental hygienist loan repayment programs.				X
9. Update the designation of dental areas of need according to regulation.				X
10.				

b. Current Activities

In FY 08, the regulations for the dental scholarship and loan repayment programs are undergoing periodic review as required by law. The review will make some minor changes to clarify terminology and to simplify management of the two programs. In FY 08, the Division began implementation of a loan repayment program for dental hygienists. This program is modeled after the existing loan repayment program for dentists.

Also in FY 08, additional ways to advertise the dentist loan repayment program have been explored, including a mailing to recently licensed dentists and dental hygienists. DDH is also

exploring better ways of working with the VCU financial aid office (which coordinates the university aspects of the scholarship program) to ensure that deadlines are met and that students are being made aware of the financial support programs that the state has to offer.

c. Plan for the Coming Year
Efforts to market the dentist and dental hygienist loan repayment programs and increase participation in those programs will continue next year. The periodic review of regulations for the program will be completed.

Dr. Karen Day, Director, Division of Dental Health, will continue to serve on the Virginia Medicaid Dental Advisory Committee. This committee will continue to monitor provider participation in the Smiles for Children program and the percentage of eligible children receiving Medicaid/FAMIS dental services.

State Performance Measure 7: *The proportion of children (0-21 years) who receive genetic testing.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				32	35
Annual Indicator		28.7	26.4	29.9	34.5
Numerator		2560	2438	3431	3569
Denominator		8913	9234	11493	10330
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	38	39	40	41	42

Notes - 2007
Data for the numerator are from three contracted genetic centers and include all children seen under age 21 (both new and follow up)

Data from denominator are from birth defects cases mandated to be reported through Virginia Congenital Anomalies and Reporting System. These are only children (up to age 2) hospitalized with certain defects as mandated in the Code of Virginia.
These data are provisional as the measurement parameters are being refined.

Notes - 2006
Data for the numerator are from three contracted genetic centers and include all children seen under age 21 (both new and follow up)

Data from denominator are from birth defects cases mandated to be reported through Virginia Congenital Anomalies and Reporting System. These are only children (up to age 2) hospitalized with certain defects as mandated in the Code of Virginia.

Notes - 2005
Data for the numerator are from three contracted genetic centers and include all children seen under age 21 (both new and follow up)

Data from denominator are from birth defects cases mandated to be reported through Virginia

Congenital Anomalies and Reporting System. These are only children (up to age 2) hospitalized with certain defects as mandated in the Code of Virginia.

a. Last Year's Accomplishments
The Pediatric Screening and Genetic Services (PSGS) unit of Division of Child and Adolescent Health (DCAH) continued to contract with three genetic/metabolic treatment centers to assure that genetic services are available to all children and their families in the state. Contractual relationships exist with Children's Specialty Group, Eastern Virginia Medical School, the Departments of Genetics at University of Virginia, and the Department of Human Genetics, Virginia Commonwealth University. DCAH also contracted with the Genetics and IVF Institute for genetic services for prenatal patients in the Northern Virginia area.

These centers continued to submit quarterly activity reports documenting numbers of patients seen per quarter and annually. The number of Virginia Congenital Anomalies Reporting and Education System (VaCARES) hospitals reporting online was maintained at 99 percent. The program's genetic counselor resigned and the position was vacant for approximately six months. During that time frame, some of the quality assurance measures initiated, such as onsite visits to hospitals, were placed on hold. Monthly reports of hospital reported patients and an annual progress report were continued. This feedback to each hospital has generated positive results from the hospitals in the form of the expressed desire to continue to improve individual hospital performance.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain contracts with genetic centers to assure genetic services are available to all children and families in Virginia.				X
2. Mail letters to parents identified through the Virginia Congenital Anomalies and Reporting System to increase knowledge regarding available resources.	X			
3. Support the Virginia Genetics Advisory Committee and its activities.				X
4. Redesign and maintain the Virginia Infant Tracking and Infant Screening web-based data system to provide better surveillance of genetic screening and results.				X
5. Strengthen referral systems to ensure that all children and families are referred for genetic testing and counseling when appropriate.				X
6. Develop family genetic history tool to help families identify their risk for genetic inherited disorders.		X		
7. Review and make recommendations regarding proposed legislation or policies addressing genetic testing.				X
8.				
9.				
10.				

b. Current Activities
The Pediatric Screening and Genetic Services (PSGS) unit of the Division of Child and Adolescent Health (DCAH) contracts with three genetic/metabolic centers to assure availability of genetic services for children and families statewide.

OFHS supports the Virginia Genetics Advisory Committee (VGAC) chaired by a geneticist. This group advises the Virginia Genetics Program on planning, implementing, and evaluating services

related to maternal and child health. The group has several subcommittees including a parent involvement workgroup.

The Virginia Congenital Anomalies Reporting and Education System's (VaCARES) parent contact continued to expand in 2007. Letters to families of children diagnosed with specific disorders include information on available genetic services and a fact sheet on the child's specific disorder.

PSGS, in consultation with VGAC, finalized a family genetic history tool to help families identify risks for genetic inherited disorders. The tool is posted on the VDH website.

The Virginia Early Hearing Detection and Intervention Program (VEHDI), through CDC grant funding, is working to redesign the Virginia Infant Screening and Infant Tracking System (VISITS). This database tracks infants and children diagnosed with genetic and heritable disorders, including birth defects mandated to be reported.

c. Plan for the Coming Year

The Pediatric Screening and Genetic Services (PSGS) unit of the Division of Child and Adolescent Health (DCAH) will continue contracting with three genetic/metabolic treatment centers to assure that genetic services are available to all children and their families in the state. Contractual relationships will continue with Eastern Virginia Medical School, the Departments of Genetics at University of Virginia and Virginia Commonwealth University, and the Genetics and IVF Institute.

In FY 09, the Virginia Genetics Advisory Committee (VGAC) will continue efforts on provider education regarding genetic services. VGAC and PSGS will continue efforts to develop and disseminate the family genetic history tool.

The Virginia Infant Screening and Infant Tracking System (VISITS) II will continue to be redesigned and is slated for completion in 2008. This redesign will link VISITS to the new Electronic Birth Certificate database. This linkage will help more timely identification and de-duplication of birth defects cases because birth demographics will be available to those entering screening and defects data.

VISITS II will also provide an automated referral system for at-risk and diagnosed children to Part C (early intervention) and Care Connection for Children (CCC) databases, respectively. This automated system will strengthen referrals and will continue to be a programmatic focus so that all children and families with identified genetic disorders will have access to case management services and assistance with obtaining genetic services and coverage.

Another CDC grant, CATPIP II, is providing for improved birth defects case identification and referrals to needed services including genetics.

State Performance Measure 8: *The percent of women reporting substance use during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				6.6	6.3
Annual Indicator	7.3	7.0	6.6	6.5	6.7
Numerator	7942	7789	7412	7380	7059
Denominator	108354	111239	111583	113392	105349
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**

Annual Performance Objective	6	5.7	5.4	5.3	5.2

Notes - 2007
2007 pregnancy data is not yet available. Entry is an estimate based provisional birth data.

Notes - 2006
Data from 2006 birth, fetal death, and intentional termination of pregnancy certificates.

Notes - 2005
Data from 2005 birth, fetal death, and intentional termination of pregnancy certificates.

a. Last Year's Accomplishments
An interagency task force, comprised of DMHMRSAS, VDSS, DMAS and VDH began exploring ways to train providers in screening and referral across the state. This group provided technical assistance to DSS staff in the development of Provider Guidelines on the Identification of Substance Exposed Infants, which was distributed to all DSS staff working with the Child Protective Services unit. This group also revised the existing brochure, Perinatal Substance Use: Promoting Healthy Outcomes A Guide for Hospitals and Health Care Providers.

This same group sponsored two meetings of advocacy groups for women and children that would have an interest in substance exposed infants. Representatives from the Governor's Office for Substance Abuse Prevention, the Virginia Federation of Families, The Family Development Project -- ARC of Virginia, the Virginia Poverty Law Center, March of Dimes, and CHIP of Virginia discussed how their perspective agency/organization had addressed this issue and what activities they would be willing to assume in preparation for the next General Assembly.

In FY 07, VHSI introduced "I Am Concerned: A Brief Intervention for the Primary Prenatal Care Setting" to staff to identify Healthy Start clients who use substances during pregnancy. The brief intervention includes education, counseling, and referral for women identified as using tobacco, alcohol, and illicit drugs. The curriculum was included in Resource Mothers training.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Begin to analyze data reporting substance use through PRAMS and develop strategies for reducing abuse.				X
2. Participate in the Fetal Alcohol Syndrome Disorder Task Force to develop strategies to reduce substance use during pregnancy.				X
3. Continue to promote concerns related to substance abuse and smoking cessation from through the RPC's, Healthy Start, health district prenatal clinics and other VDH sponsored programs.		X	X	
4. Collaborate with DMAS to update and improve screening of substance use during pregnancy for women in BabyCare.		X		X
5. Participate in an interagency task force to identify a methodology to train providers in screening and referral of substance abusers.		X		X
6. Review and make recommendations regarding proposed legislation or policies addressing substance use treatment services for women.				X
7. RPCs will monitor substance abuse trends in individual regions of Virginia through FIMR.		X		X
8.				
9.				

10.				

b. Current Activities
The percent of women self-reporting substance abuse is decreasing and reflects a statistically significant downward trend in substance abuse from 7.3% in 2003 to 6.5% in 2006.

See information in national performance measure 15 for information on current activities related to smoking cessation.

Virginia was awarded funding for the CDC funded Pregnancy Risk Assessment Monitoring System (PRAMS). The survey is currently being conducted within Virginia and will not be available until 2009.

Medical practitioners within VDH prenatal clinics were provided with ACOG's Drinking and Reproductive Health: A Fetal Alcohol Spectrum Disorders Prevention Tool Kit. This continuing educational module provides insight into current assessment of alcohol usage of the mother, dialogue techniques, and intervention strategies. A reference guide on the T-ACE screening tool and a table of standard-sized drink equivalents was included.

VHSI staff screen for substance use during pregnancy and interconceptional period, provide education and counseling to women, and refer those who use substances to Project LINK and the Community Services Board for diagnosis and treatment.

An attachment is included in this section.

c. Plan for the Coming Year
Since birth certificate information is self-reported, there is some concern that there may be an under reported incidence of substance abuse. PRAMS surveys are confidential and may indicate a more valid percentage of alcohol and smoking. The PRAMS survey does not provide information pertaining to illicit drug usage. As Virginia PRAMS data becomes available in 2009, we will be comparing and contrasting both data sets.

See information in national performance measure 15 for information on future activities related to smoking cessation.

OFHS will continue to participate in the Substance Abuse Services Council, which made recommendations to the Governor, the General Assembly, and the BDMHMRSAS on the coordination of public and private efforts to control substance abuse in Virginia. Recommendations included a call to appropriate funds for a universal statewide screening protocol for risks related to substance abuse, mental illness, and domestic violence and to support increased access to treatment for pregnant women and women with dependent children through targeted case management. In the coming year, the revised Perinatal Substance Use: Promoting Healthy Outcomes will be distributed by DSS, VDH, and DMHMRSAS to birth hospitals, local health departments, providers, CSBs, home visiting programs, and other health care organizations caring for pregnant women.

It is planned that the Virginia Council on Folic Acid and the FASD Task Force be combined into a Birth Defects Prevention Committee, which would become a subcommittee of the Virginia Genetics Advisory Board. There is overlap of many of the organizations and members of these two groups and there is interest in focusing efforts in a more efficient way. OFHS was represented at the National FASD meeting sponsored by the FASD Center of Excellence and a draft statewide plan has been developed. This plan will be integrated into the already existing statewide plans developed by these two other groups. Work with this group will continue during FY 2009.

RPCs will monitor substance abuse trends in individual regions of Virginia through FIMR. Trends will be discussed during consortium meetings with key stakeholders planning and implementing programs and services unique to the needs of regional citizens. These activities will be reported and monitored for completion through DWIH.

VHSI staff continue to screen for substance use during pregnancy and the interconceptional period, provide education and counseling to women, and refer those who use substances to Project LINK and the Community Services Board for diagnosis and treatment.

State Performance Measure 9: *The percent of women with an ongoing source of primary care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				90	91
Annual Indicator	88.6	86.8	87.3	88.6	88.9
Numerator	2494343	2513554	2565851	2626848	
Denominator	2813758	2895257	2937536	2965666	
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	92	93	94	94	94

Notes - 2007
2007 BRFSS data not available. Entry is an estimate based on trend.

Notes - 2006
2006 weighted BRFSS data.

Notes - 2005
2005 Final Weighted BRFSS data.

a. Last Year's Accomplishments
This is a new state performance measure. The baseline is 86.8% in 2004 (using BRFSS data).

The Home Visiting Consortium, under Title V leadership, is part of the Governor's Early Childhood Initiative. Since December 2006, the Commonwealth's ten home visiting programs have met to review national research and consider alternative designs with the goal of improving effectiveness and efficiency. The group concluded that improvements can be achieved over the next two years through development of a comprehensive collaborative model including all existing state home visiting programs; this will be supported by various federal funding streams and sponsored by various state agencies. Families will benefit from this multidisciplinary approach. The group is focused on state leadership and structure, technical assistance to local communities with or without programs, core staff training, cross-program screening, data collection and evaluation processes, and systematic connections with medical providers and child care providers.

The Consortium identified training currently conducted by all programs and the data collected by each program. Core training is being identified for all of Virginia's home visitors. Communities are being encouraged to develop more efficient intake, screening, and referral processes. Data elements that might be used to track the family's and the child's progress across the first five years prior to school entry are being examined. In addition, the family planning waiver was reviewed and re-submitted by DMAS for a waiver to serve women.

OFHS promoted women's health across the life span through numerous awareness initiatives, such as:

•Coordinated the efforts of public and private entities and procured and disseminated promotional and educational materials for National Women's Health Week. As a result, Virginia led Region 3 in the number of sponsored events posted on the national website and ranked in the top 10 nationally.
•A proclamation for National Women's Health Week was issued by the Governor. To promote National Wear Red Day, VDH issued a press release that resulted in radio interviews.
•OFHS staff provided numerous presentations throughout the state to medical professionals who stressed the importance of GDM screening based on risk and the need for Type 2 risk reduction education. As a result of this awareness effort, the Virginia Diabetes Council selected this issue as their 2007 area of focus and also worked to increase awareness among providers and women.

The Code of Virginia 32.1 -- 11.5 was amended in 2006, permitting the Board of Health to approve pilot programs to improve access to obstetrical and pediatric care by establishing birth centers. Funds from both the 2007 and 2008 General Assembly have been allocated to VDH to support this effort. OFHS staff assisted VDH Community Health Services with contract oversight and provided technical assistance to the two pilot projects. Both centers have plans to open during FY 09.

A Colorectal Cancer (CRC) Pilot Screening Project was initiated July 1, 2006 through three Every Woman's Life (EWL) provider sites. The sites were selected based on Virginia CRC incidence and mortality data. Women enrolled in the EWL program aged 50 and older were offered a Fecal Immunoassay Test (FIT), as well as a colonoscopy if the FIT result was positive. By the year's end, 1, 146 women had received a FIT and 15 colonoscopies were performed. Several colonoscopies involved the removal of benign polyps. In the second year, the pilot project was expanded to include eleven EWL providers with a goal to screen 486 women.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide case management services through Resource Mothers and the Virginia Healthy Start Initiative.		X		
2. Strengthen connections with local health care providers through program outreach activities.		X		X
3. Improve the referral systems of local health departments and community agencies via the Virginia Healthy Start Initiative.			X	X
4. Review and make recommendations regarding proposed legislation or policies addressing women's access to care.				X
5. Fully implement the GDM/BMI project.	X	X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Beginning in January 2008, Plan First began providing services for routine and periodic family planning office visits. Available for men and women, the visit includes annual physical exams, cervical cancer screening for women, testing and laboratory services related to sexually transmitted disease, and family planning. The plan also includes coverage for sterilization

procedures and all FDA approved contraception. Education and counseling is conducted in the areas of family planning options and decisions.

In 2007, OFHS was awarded An Integration of HIV/AIDS Testing and Prevention Services in Title X Family Planning Project to offer all women HIV testing. The goal is decrease the burdens associated with HIV/AIDS through increasing the number of women with known HIV status, preventing HIV transmission, and improving health outcomes through early diagnosis and treatment.

VHSI provided case management services to 185 pregnant and interconceptional women. Staff connect women to sources of health care and assist with application to insurance carriers and setting up appointments.

An attachment is included in this section.

c. Plan for the Coming Year

OFHS is promoting women's health across the lifespan and access to primary and obstetrical care is an important part of this. In the coming year, OFHS will actively support National Women's Health Week and the Wear Red campaign to raise awareness about heart disease in women, as well as encourage screening for breast and cervical cancer and other diseases.

In FY 2007, DWIH initiated a diabetes pilot program in 4 local health districts' family planning clinics. The program's purpose is to assess the prevalence of women reporting a history of Gestational Diabetes Mellitus (GDM), educate women with a history of GDM and/or a current obese status of their elevated risk for developing diabetes, ensure that all women are aware of their current glucose control status and refer to appropriate treatment services. Thus far, 726 women have been assessed for diabetes risk and educated on risk reduction with twenty-three women referred for further diagnostic screenings/treatment. In FY 2008, the GDM/BMI pilot project will end. A report of the project will be written and presented to the Family Planning Advisory committee for review and possible action. Efforts will be made to integrate this project into ongoing family planning services.

VDH will continue case management activities through the Resource Mothers Program and the Virginia Healthy Start Initiative.

VDH will continue to support health districts that provide obstetrical and intraconceptual women's health by providing financial, technical, and educational opportunities, as requested. Access to care will be monitored.

Funding for the Colorectal Project was not included in the current state budget but interest exists and efforts continue to find alternative funding.

DWIH submitted a grant application to the Centers for Disease Control to establish the WiseWoman Program within the existing Breast and Cervical Cancer Early Detection Program. If awarded, expanded services will include preventive health services to determine heart disease and stroke risk by assisting women improve their diet, increase physical activity, live tobacco free, and adopt healthier lifestyles.

The Code of Virginia 32.1 -- 11.5 was amended in 2006, permitting the Board of Health to approve pilot programs to improve access to obstetrical and pediatric care by establishing birth centers. Funds from both the 2007 and 2008 General Assembly have been allocated to VDH to support this effort. OFHS staff assisted VDH Community Health Services with contract oversight and provided technical assistance to the two pilot projects. Both centers have plans to open during FY 09.

E. Health Status Indicators

In the past, there has not been a sustained and coordinated maternal and child health surveillance effort in Virginia due in large part to the lack of long-term resources and full-time positions dedicated to surveillance activities. As a result, MCH surveillance activities related to health status indicators tended to be specific to a particular division and done through contractual arrangements using one-time funds. Over the past five years, however, leadership in the Office of Family Health Services has made a strong commitment to improving MCH surveillance capacity through the use of Title V, State Systems Development Initiative (SSDI), and other funding.

Using SSDI funds, Virginia has made significant improvements in MCH surveillance capacity in the past two years. In October 2004, a Ph.D. level MCH Epidemiologist was hired with SSDI funds via a contract with the Department of Epidemiology and Community Health within Virginia Commonwealth University's (VCU) emerging School of Public Health. In order to lead and direct MCH surveillance activities across all OFHS division, this position was placed at the office level in the Policy and Assessment Unit.

Improvements in access to health status indicators updated on a regular and timely basis have occurred since the hiring of the MCH Epidemiologist. A Memorandum of Agreement (MOA) with Vital Records and the Center for Health Statistics grants all OFHS staff access to complete statistical data files on birth, death, fetal death, linked birth-infant death and intentional terminations of pregnancy. With assistance from the CSTE Fellow, the MCH Epidemiologist established the OFHS Data Mart through which all OFHS staff may now access cleaned and standardized 1995-2004 vital records data and 1996-2004 hospital discharge data. Protocols are also in place to automatically append new data as it becomes available. Provisional data (monthly births and deaths; quarterly hospital discharges) and Census data are expected to be included in the OFHS Data Mart by the end of 2006. The Data Mart will enable OFHS staff with easy access to the health status indicators for use in program planning and evaluation. An office wide surveillance system is being developed that will establish systematic reporting and review of health status indicators.

/2009/ In 2007, Caroline Stampfel, who formerly served as a CSTE fellow, was hired as a MCH Epidemiologist. An additional CSTE fellow, Andrea Alvarez, began her two year placement in the Policy and Assessment Unit. In addition a graduate student, Jennifer Davis, from the MCHB Graduate Student Internship Program (GSIP) is working with the Policy and Assessment Unit staff this summer. //2009//

/2009/ In September 2007 the OFHS was awarded a CDC Assessment Initiative grant. This grant supports the development of innovative systems and methods to improve the way data are used to provide information for public health decisions and policy. The five-year grant supplies $250,000 each year. As a result of this funding, OFHS has acquired a new position for an IT liaison in order for OFHS staff to have a single piont of contact with the Office of Information Management (OIM). Michelle White serves as the IT liaison and the Virginia Assessment Initiative Program Coordinator. To date, access to a number of data sets has been made available to OFHS staff inlcuding vital records datasets, and linked birth and death records, and fetal deaths. In addtion, OFHS divisions have been surveyed to identify current data available and data needs and to determine potential data linkages across divisions. Other components of the survey determine existing program evaluation efforts and needs and staff training needs related to data and evaluation. //2009//

Currently the OFHS Division of Women's and Infants' Health uses data for Health Status Indicators # 01A, 01B, 02A, 02B, 07A and 07B. This information is available from the Center for

Health Statistics which also provides county/city data for local planning and evaluation efforts. The data provides a basis for developing plans and resource allocations for such initiatives as Healthy Start, Resource Mothers, and the educational programs offered by the Regional Perinatal Councils.

In 2006, Virginia was awarded a CDC Pregnancy Risk Assessment and Monitoring System (PRAMS) grant. The PRAMS data will provide additional information that will help to address issues of low birthweight and infant mortality.

The OFHS Division of Injury and Violence Prevention is responsible for addressing Health Status Indicators # 03A, 03B, 04A, 04B and 04C. The division uses these data to target education and prevention efforts and to evaluate these efforts. The primary source of information for planning and policy development is the hospital discharge database.

Health Status Indicators # 05A and 05B are primarily monitored by the Office of Epidemiology's Division of Disease Prevention. This information is used to target education, prevention, and testing efforts to appropriate subpopulations and geographic areas. The OFHS Family Planning Program (Title X) located in the Division of Women's and Infants' Health coordinates planning and services with the Division of Disease Prevention.

The demographic data (Health Status Indicators # 06A, 06B, 08A, 08B, 09A, 09B, 10, 11, and 12) are used primarily for long-range planning. Child death statistics are used by the Child Fatality Review Team (funded by Title V) located in the Virginia Department of Health's Office of the Chief Medical Examiner. The team makes recommendations for policy and procedures to prevent child deaths. The Regional Perinatal Council's FIMR teams use data on fetal and infant deaths to develop strategies for addressing the causes of deaths within communities across the state. Data on enrollment in WIC, Medicaid and SCHIP inform outreach efforts. Data on households headed by a single parent, TANF, foster home care, enrollment in food stamp programs, juvenile crime arrests and high school drop-out rates are not used specifically for MCH programs. Poverty statistics inform planning for most human service programs for Virginia families.

An attachment is included in this section.

F. Other Program Activities

Title V funds the Division of Injury and Violence Prevention to coordinate a statewide program to involve health care providers in intimate partner violence prevention, assessment, counseling and referral. During 2007, three train-the-trainer events to certify advocates and health professionals to teach the RADAR curriculum for identifying, assessing, and managing intimate partner violence (IPV) in the health care setting were held. These trainings (conducted in Hampton, Tidewater, and Williamsburg) resulted in 85 certified RADAR trainers, for a total of nearly 170 throughout the Commonwealth. Over 1,400 health care providers from all regions of the state were trained using the RADAR curriculum. A web-based RADAR course was granted continuing medical education credits and continuing education units by the VCU School of Continuing Medical Education. From May through December, nearly 70 professionals completed the course. Additional RADAR curricula for geriatric care providers and for school counselors, nurses, and others that may work with adolescents and teens experiencing dating violence were created and disseminated. Existing curricula for primary care, OB/GYN, pediatric, emergency and dental providers were revised and updated to reflect current research findings and data.

Over 15,000 brochures, resource cards, buttons, and other written materials were mailed, as requested via the Project RADAR resource order form. Approximately 7,500 additional resources were disseminated in training workshops and mass mailings to providers. Four radio public service announcements on domestic violence as a healthcare issue were developed and broadcast throughout the state for over two months. An outdoor advertising campaign encouraging victims of intimate partner violence to talk to their health care providers about abuse

and providing the Virginia Family Violence & Sexual Assault Hotline was implemented. This campaign included billboards in both rural and urban areas throughout the state, as well as bus ads in the Richmond and Roanoke regions. In recognition of "Health Cares About Domestic Violence Day", foam board tabletop displays and brochures, along with a fact sheet on IPV as a health care issue, were mailed to all local health departments in Virginia.

In collaboration with the Old Dominion University College of Health Sciences, a hospital domestic violence policy analysis project was coordinated. In 2007, 30 of Virginia's hospitals participated, providing their relevant abuse policies to be analyzed based on best practice standards (as defined in the model policy developed in 2006), as well as criterion set forth by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). Each participating hospital was provided with a detailed analysis of their policy as well as a revised policy that encompassed recommendations made. The contract for this project was renewed; it is anticipated that another 30 hospitals' policies will be reviewed and a report on the findings written and disseminated in 2008.

The Director of DIVP presented on the role of maternal and child health programs in bullying prevention on a Children's Safety Network web seminar early in 2008. A transcript of the presentation is featured as a "Spotlight on the States" on the Children's Safety Network website.

The Division of Injury and Violence Prevention is currently using Title V resources to support a series of trainings on dating violence prevention. The Virginia Department of Health, in collaboration with the Virginia Center for School Safety, is providing three Choose Respect: Healthy Teen Relationships trainings. All training participants will receive a copy of the CDC developed Choose Respect video and curriculum guide. The course aims at enabling participants to: define dating abuse; identify unhealthy or abusive relationships; recognize the qualities of healthy relationship behavior; demonstrate a way to tell youth in unhealthy relationships how to end the relationship or get help; and develop activities to promote Choose Respect and healthy, respectful relationships in the community. It is anticipated that 300 school safety practitioners (teachers, school resource officers, school security officers, school administrators, and staff) will be in attendance. The Division is also promoting Safe Dates, an evidence based teen dating violence curriculum.

In October 2007, VDH and the Office of the Chief Medical Examiner published a report from the Virginia Maternal Review Team, Pregnancy-Associated Maternal Death in Virginia 1999-2001. Three years of data were reviewed to describe the maternal death reality in Virginia and to document recommendations. The recommendations included:

•Increase statewide appropriations dedicated to decreasing social and medical issues pertaining to maternal death
•Strengthen laws related to medical history, screening, and the care and well-being of pregnant and postpartum women
•Enforce all domestic violence laws
•Adopt Centers for Disease Control and Prevention's revisions to the certificate of death

The VDH internal subcommittee of the Bright Futures Virginia project has met this year to identify next steps. The group agreed that all educational materials developed or purchased for use with families of children ages 0-21 would be screened by each division for compatibility with the revised Bright Futures Guidelines. The current Bright Futures web site, based on the previous Guidelines edition and housed with a university medical school, will cease on June 30, 2008. The Bright Futures Virginia group will be working with another state university to develop a new web site by the end of 2008 that will provide tools and updated information for health providers, nurses, social workers, and nutritionists. Based on multicultural community focus group feedback, the web site will also have health information sections for parents and young people. As this new web site develops, VDH will work closely with the national project at AAP.

DWIH is working with faculty at Virginia Commonwealth University to repeat the perinatal provider survey to assess for practices regarding screening for perinatal depression. The survey will be conducted in FY 09.

OFHS served on the planning committee for the Richmond Regional Summit on Infant Deaths sponsored by the Richmond City Healthy Start. The three-day summit addressed the multiple issues surrounding infant mortality and what communities can do to improve pregnancy outcome. National and state experts provided technical information in conjunction with several work sessions to develop a regional plan.

The Partners in Prevention Program (PIP) was established in 1997 with TANF funds to focus on the prevention of nonmarital births without increasing the incidence of abortions through community based programs for those aged 20-29. The program required services be multi-level, over-time interventions, such as promoting the delay of sexual activity and conception until marriage; effective family planning; decreasing high-risk sexual behavior; male responsibility; and healthy attitudes and behavior intentions regarding marriage, family, and career.

Although the Virginia rate continues to increase since the implementation of the program, the rate of increase is less that experienced nationally. The 2006 evaluation showed that program produced statistically significant changes in seven program measures on participants' knowledge, attitudes, and behaviors pertaining to family planning, the benefits of marriage on children and families, and male responsibility. In 2007, the program delivered over 6,000 direct service contacts and preliminary analysis of core survey data show that statistically significant results were produced in all the 27 measures; men comprised greater than 50 percent of program participants.

G. Technical Assistance

General Systems Capacity

1. Regional forum on Infant Mortality. Virginia would like to request that a regional forum on infant mortality be conducted in order for the Region 3 states to share their successful infant mortality initiatives and hear from invited experts in the field of infant mortality research. In Virginia, the Governor has made infant mortality reduction a priority and has convened a Health Reform Commission that is tasked with addressing this issue.

2. Virginia has not assessed the structure and services of the child development clinics in a number of years. In the meantime, there have been changes in the service environment that requires us to revisit the current structure to determine the appropriate continuum of services and how Title V funds can be most efficiently and effectively spent while not duplicating existing services.

3. The administration of Part C may be transferred to VDH. We would like technical assistance to determine the most effective way to integrate Part C with existing CSHCN programs. If not relocated, the relationship between Part C and CSHCN remains an issue that needs to be examined and a plan developed to clarify the relationship so that the most effective and efficient service delivery system can be established for Part C children and their families.

4. Technical assistance on how to establish and work effectively with advisory groups. Much of our MCH work includes the participation of advisory groups. The identification of advisory group members and the role of the advisory group are extremely important in identifying priorities and promising programs, targeting resources, developing policies, and evaluating program outcomes. New England Serve recently provided this training for our CSHCN program. We are requesting that they provide a similar training for the remaining MCH program staff.

V. Budget Narrative

A. Expenditures

State fund expenditures for Maternal and Child Health Services listed on Form 3 exceed that budgeted. Because program income expectations were not realized, state matching funds were employed to ensure that the program was funded at the projected level. Virginia funded the MCH program at $207,853 higher than budgeted.

Form 4: Expenditures for pregnant women served fell short of that budgeted by $1,954,618. The expended amount is based on the actual visits while the budgeted amount is an estimate based on the prior year's visits. The actual number of pregnant women served comprised 5% of the total number of individuals served. Expenditures for services to Children 1 to 22 exceeds the budgeted amount by $917,614. This result of filling vacancies in several positions providing such services during this reporting period and of serving a higher proportion (25% of total served) than expected. This is also true for Children with Special Health Care Needs (CSHCN) and Others. Additionally, Form 5 shows that Direct Health Care has a variance from the budgeted amount. This reflects a continuing decrease in the provision of direct clinical services in the local health departments (LHD) as well as reasons identified above. Virginia continues to emphasize health education and translation services geared toward pregnant women, infants and children. Additionally, Virginia has been moving toward enabling and population-based services as opposed to direct provision of care.

Form 5 indicates significant variation in expenditures by type of service. The rationale behind this is discussed above. Also, a concerted effort to secure reimbursement through other sources (Medicaid, commercial insurance, etc.) for direct service provision has proven extremely effective. Infrastructure building expenditures fall below that budgeted due to prior year activities that resulted in enhanced infrastructure as well as cost saving activities at the state level.

B. Budget

The Title V block grant budget provides funds for Maternal and Child Health (MCH) services, primary care for children and adolescents, and preventive and maintenance services to Children with Special Health Care Needs (CSHCN). Preventive and primary care services include policy and procedural oversight, nutrition services, Local Health Department (LHD) agreements, pharmacy and laboratory testing, Regional Perinatal Coordinating Councils (RPCC), Fetal/Infant Mortality Review, Newborn screening/follow up, and reducing health problems and risk factors. Other services provided are promotion of health and provision of comprehensive health services, assessment, management of secondary and tertiary care, injury prevention, Child Care Nurse Consultant, Medical Home/Access to Care, Resource Mothers (RM), primary care, school health, family planning (under age 22), teen pregnancy prevention, maternal health (under age 22), laboratory testing, pharmacy, sickle cell services, and dental health.

Population services include policy and procedural oversight concerning women's services, agreements with LHD for family planning services, laboratory testing and pharmacy services.

Services for CSHCN include family-centered, community-based coordinated care for persons from birth through age 20 who have or are at risk for disabilities, handicapping conditions, chronic illnesses and conditions or health related educational or behavioral problems, and development of community-based systems of care for such children and families.

Administrative costs are incurred by the Virginia Department of Health (VDH) in administering

grants by individuals other than those solely supporting the grant. As in previous years, the Federal Fiscal Year (FFY) 2009 budget does not include administrative costs. VDH's definition of administrative costs includes management and policy direction, accounting and budgeting services, personnel services, and support services for supplies, equipment, etc.

Virginia budgets 30% or more of MCH funding for preventive and primary care services for children. At least 30% (37% for FFY2009)is also budgeted for CSHCN. $11,321,109 (49% of total funds) is used for preventive and primary care services for children (including infants) and adolescents; $8,548,592 (38% of total funds; 36% of federal funds) is for CSHCN. The remaining funds will be used for pregnant women, mothers, and non-pregnant women over 21 years. These shifts are the result of the effort the align funding with the true distribution of populations served.

State funds provided for FY2009 for MCH exceed the fiscal year 1989 level. Between October 1988 and September 30, 1989 (FY89), $8,718,003 in state funds for Title V services was expended; the FY2009 state allocation, including program income, is $10,758,987.

During FY89, $9,033,260 in federal fund was expended and Virginia overmatched the 4:3 requirement by $1,943,058. State funds expended in 1989 included all funds used for the Title V match and overmatch for all Title V-funded units and for childhood immunization. Title V funds are used to carry out the purposes of this title and the following activities previously conducted under the Consolidated Health Programs: Lead poisoning prevention and Genetics. Virginia did not receive Sudden Infant Death Syndrome (SIDS) funds; however, the Division of Women's and Infants' Health provides information to families of SIDS infants. Based on the State's previous use of funds under this title, a reasonable proportion of allotted funds will be used to carry out the purposes described in Section 501(a)(1)(A) - (D). The total budget is estimated to be $23,104,303.

Title V funds ($14,555,711) will be used for preventive and primary care services for pregnant women, non-pregnant women of child bearing age, mothers, infants, children and adolescents. These funds will be used for family planning, LHD prenatal and child health services, genetic testing/counseling/ pharmacy and education, RPCCs, primary care, injury prevention, and local programs to reduce infant mortality. These services meet Section 501(a)(1) (A) and (B). Title V funds ($8,548,592) will be used for CSHCN, meeting purposes in Section (a)(1)(C) and (D).

Additional federal funds: Centers for Disease Control and Prevention (CDC) programs total $12,404,169; of this, $5,367,526 is targeted to MCH populations. Funds for Healthy Start are $1,050,000; SSDI, $94,644; and CISS, $142,917. Virginia no longer holds an Abstinence Education grant.

Another source of MCH targeted funding is the Women, Infants, and Children (WIC) nutrition program estimated to be $61,511,469. In FY09, $6,737,299 in "other" federal funds includes: Department of Medical Assistance Services for RM ($447,500). Title X provides $4,527,671; Department of Social Services provides Temporary Assistance to Needy Families funding totaling $1,077,150 (Teen Pregnancy Prevention, Partners in Prevention, etc.); Maternal and Child Health Bureau additional funds include Universal Hearing Screening and Oral Health totaling $284,978. SAMSHA funds Youth Suicide Prevention at $400,000.

There are no known unobligated balances for the state fiscal year ending June 30, 2007. Funds will be used to enhance enabling, population-based services and infrastructure activities and to support innovative research-based pilot projects.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.